STATE OF MAINE WORKERS' COMPENSATION BOARD

OFFICE OF MONITORING, AUDIT AND ENFORCEMENT



FORMS MANUAL

EFFECTIVE JANUARY 1, 2013

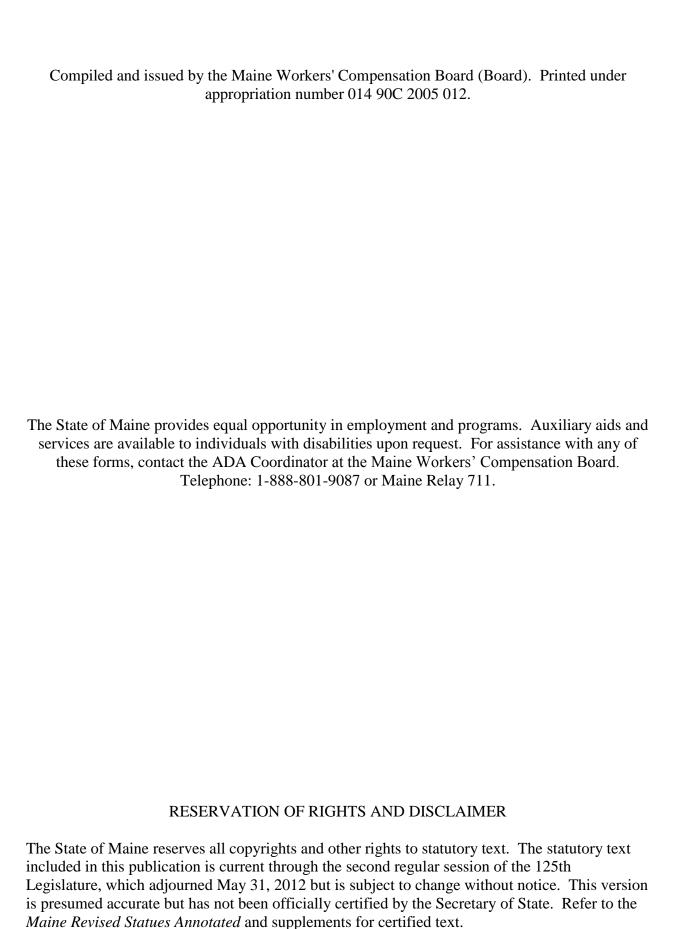


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STATE OF MAINE WORKERS' COMPENSATION BOARD

CENTRAL OFFICE

27 State House Station Augusta, Maine 04333-0027 (207) 287-3751 1-888-801-9087 Maine Relay 711 FAX (207) 287-7198

Abuse Investigation Unit	(207) 287-7065
Claims Management Unit	(207) 287-2002
FAX (for Claims Management forms only)	(207) 287-5895
Office of Monitoring, Audit and Enforcement	(207) 287-7067

REGIONAL OFFICES

AUGUSTA 24 Stone Street, Suite 102 Augusta, Maine 04330-5220 (207) 287-2308

1-800-400-6854

CARIBOU

One Vaughn Place 43 Hatch Drive, Suite 110 Caribou, Maine 04736-2347 (207) 498-6428 1-800-400-6855

BANGOR

106 Hogan Road, Suite 1 Bangor, Maine 04401-5640 (207) 941-4550 1-800-400-6856

LEWISTON

36 Mollison Way Lewiston, Maine 04240-5811 (207) 753-7700 1-800-400-6857

PORTLAND 62 Elm Street Portland, Maine 04101-3061 (207) 822-0840 1-800-400-6858

OTHER RESOURCES OFFERED BY THE MAINE WORKERS' COMPENSATION BOARD

(Available from Central Office) (Fee Schedule may apply)

Facts About Maine's Workers' Compensation Laws (an employee pamphlet)

Maine Workers' Compensation Act of 1992, Title 39-A, M.R.S.A.

Maine Workers' Compensation Board Rules and Regulations

Maine Workers' Compensation Board 1993-2012 Weekly Benefit Tables

Maine Workers' Compensation Board Medical Fee Schedule

Maine Workers' Compensation Board Forms (First Reports of Injury, Wage Statements, etc.)

Training workshops presented by Board staff (call Office of Monitoring, Audit & Enforcement 287-7067)

MAINE WORKERS' COMPENSATION BOARD FORMS REFERENCE GUIDE

	BOARD FORM	STATUTES	RULES	FILING REQUIREMENTS
WCB-1	First Report of Injury	§303	1.7 3.1 3.4 8.13 8.16	Filed electronically within 7 days notice/knowledge of incapacity.
WCB-2	Wage Statement	§153(4) §205(8) §303	1.7	Filed within 30 days notice/knowledge of a claim for compensation.
WCB-2A	Schedule of Dependents and Filing Status Statement	§303	1.7 8.9	Filed within 30 days notice/knowledge of a claim for compensation for dates of injury prior to 1/1/13.
WCB-2B	Fringe Benefits Worksheet	§303	1.7 8.9	Filed within 30 days notice/knowledge of a claim for compensation.
WCB-3	Memorandum of Payment	§153(1)(B) §205(7)	1.1 1.7 8.12	Filed within 14 days notice/knowledge of a claim for incapacity or death benefits.
WCB-4	Discontinuance or Modification of Compensation	§205(9)(A)	1.7 8.11 8.12	Filed within 14 days after benefits are reduced or discontinued pursuant to 39-A M.R.S.A. §205(9)(A).
WCB-4A	Consent Between Employer and Employee		8.18	Filed when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity, or a modification or discontinuance in ongoing weekly incapacity benefits.
WCB-6	Certificate Authorizing Release of Benefit Information	§221(5)		Used to request information about payments made to an injured employee from the Social Security Administration or from an Employee Benefit Plan.
WCB-7	Certificate Authorizing Release of Unemployment Information	§220		Used to request information about unemployment payments made to an injured employee.
WCB-8	Certificate of Discontinuance or Reduction of Compensation	§205(9)(B)(1)	1.7 8.15	Filed via certified mail no later than 21 days prior to the effective date of the discontinuance or reduction of benefits. pursuant to 39-A M.R.S.A. §205(9)(B)(1).
WCB-9	Notice of Controversy	§313(1)	1.1 1.7 3.4 8.2 8.12	Filed electronically within 14 days of a claim for incapacity or death benefits.

MAINE WORKERS' COMPENSATION BOARD FORMS REFERENCE GUIDE

BOARD FORM				
WCB-10	Lump Sum Settlement	§352	1.7	Filed to request approval of a lump sum settlement.
WCB-11	Statement of Compensation Paid		1.7 8.1 8.12	Filed within 195 days from the date of injury when indemnity benefits are paid and annually on the anniversary date of the injury subsequent to that. Final report when no further benefits are anticipated.
WCB-220	Limited Certificate Authorizing Written Release of Medical/Health Care Information	§208(1)	12.18	Used to obtain medical records and information, pre-existing and subsequent to the workplace injury.
WCB-230	Employment Status Report	§308(2)	1.8	Used to obtain employment information from an employee receiving compensation under the Act who has not returned to that person's previous employment.
WCB-231	Employee's Return to Work Report	§308(1)	1.7 8.17	Filed within 7 days of the person's return to work.
WCB-231A	Employee's Return to Work Report	§205(9)(B) §308(1)	1.7 8.15	This report is sent to the employee with the Certificate of Discontinuance or Reduction of Compensation or the Petition for Review.

Effective 1/1/2013

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

4 14400	FLE NUMBER	All bearings.

1s. OSHA 300 CASE NUMBER (Fapplicable):

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2a. ☐ LOST TIME - ONE OR MORE DAYS 3. ☐ LOST FARNINGS BUT NO LOST TIME	ъ. w/	AS EMPLOYEE PAID FOR % DA 4. MEDICALHEALTH		N DAY OF I	NJUF		B □ FATALITY	NO DATE OF	DEATH:		
6a. ☐ OCCUPATIONAL DISEASE		6b. DATE OF LAST EXPOS		,					1	MM DD YYYY ALLY RELATED:/_	,
			MM D	0 11111						MM DO	YWY
7a. CORRECT PRIOR REPORT		7b. DATE OF CORRECTION		·m		7c. D/	ATE CORR	ECTION 8	ENT TO W	WW DD YYYY	
						YER					
8. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):		9. FEDERAL EMPLOYER I	DENTIFICATIO	N NUMBER	(FEI	IN):	10.	EMPLOY	ER NAME		
, , ,											
11. STREETIP O BOX MAILING ADDRESS:		12. CITY:			13.	STATE:	14.	ZP:	П	15. TELEPHONE NUMBER ()	:
		47 5151 6157 1 66170			_						
16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:		17. EMPLOYER LOCATION MAILING ADDRESS:	I IF DIFFEREN	FROM	1					OYER'S PREMISES?	/ES □ NO HERE THE EMPLOYEE WAS
		1			1	NJURED OR EXPO		T I I G G		SOG III CON CONTEN	ETE THE CAN COTEC MAD
		1			1						
(check one) INSURER			RD PARTY	ADMINIST	RA	TOR (TPA)				OMINISTERED EMPLO	YER
19. INSURANCE / TPA COMPANY NAME:	ı	20. POLICY NUMBER:					21.	INSURER	RFILENUN	MBER:	
22. STREET/P.O. BOX MAILING ADDRESS:	П	23. CITY:			24.	STATE:	25.	ZIP:	Т	26. TELEPHONE NUMBER	
										()	
				EMP	210	YEE					
27. LAST NAME:	П	28. FIRST NAME:		29. Mt	Т	30. TELEPHONE NU	JIMBER:	31	1.80CML	SECURITY NUMBER:	32. GENDER:
	ı			l	1	()			XXXX-X	OX-	☐ MALE ☐ FEWALE
33. STREET/P.O. BOX MAILING ADDRESS:	┪	34. CITY:		_	┪	35. STATE:	38.	ZIP:		37. DATE OF BIRTH:	
	ı				1						
38 OCCUPATIONAIDE TITLE	_	M. BATT AT LINE			Ц					MM DD YYYY	N. Surray
38. OCCUPATION/JOB TITLE:	ı	39. DATE OF HIRE:		KLY WAGE	AI I	TIME OF INJURY:				WORK FOR ANOTHER EM E8, GIVE NAME AND ADD	
		MM DD YYYY	\$								
				CLAIM IN	FO	RMATION					
42. DATE OF INJURY OR ILLNESS:	43. D/	ITE OF INCAPACITY:			BE	GAN WORK	45.	DATE EN	PLOYER	NOTIFIED INSURER/TPA:	
1 1			(e.g. 73	0 a.m.):				,	,		
MM DD YYYY	MM	DD YYYY					-	M DD			_
DATE EMPLOYER NOTIFIED:	DATE	EMPLOYER NOTIFIED:	8. TIME C	F INJURY (44	1:10 p.m.J:	47.H	AS EMPL	OYEE RET	TURNED TO WORK? THE	8 □ NO
			1				IF	YES, GIVE	E DATE: _	MM DD YYYY	
MM DD YYYY		DD YYYY									
48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):	- 1	0. BODY PART(s) AFFECTED (e.g. lower right t	bream):			50. ALL EI USING W	QUIPMEN HEN THE	T, MATERI EVENT OC	IALS, OR CHEMICALS EMP CURRED (e.g. acetylene to	LOYEE WAS rch, metal plate):
, ,	ı										, , ,
51. SPECIFY ACTIVITY THE EMPLOYEE WAS	NGAGE	D IN WHEN THE EVENT	52. HOW	NJURY OF	E LL	NESS OCCURRED.	DESCRIBE	THE SEC	XUENCE O	F EVENTS AND INCLUDE A	MY OBJECTS OR SUBSTANCES
OCCUPRED (e.g. cutting metal plate for flooring)	i.		slipped o	RECTLY IN.	p m	etal. As worker fell, w	ofter brush	ILL. (e.g. v ed against	hot metal.)	ped back to inspect work an	•
			1								
WAS ACTIVITY PART OF NORMAL JOB DUTIES	37 🗆 Y	ES 🗆 NO									
53. HOSPITALIZED OVERNIGHT AS INPATIENT?	4.V	VAS THE EMPLOYEE TREATERS.	HEALTH CARE	PROVICER N	AME	58. MAILING AD	DRESS:			57. TELEPHONE N	UMBER:
YES NO		YES NO:				1				()	
	_		PE	REPARER	IN	FORMATION					
58. PREPARER NAME AND TITLE (TYPE OR P	RINT):			PHONE NU					Т	60. DATE SENT TO WCB:	
			()							MM 00 7777
THE STATE OF MAINE DOES NOT DISCR THIS FORM IS AVAILABLE IN ALTERNATI	MINAT	E ON THE BASIS OF DISAB	ILITY IN ADM	ISSION TO), A	CCESS TO, OR OF	ERATION	OF ITS	PROGRA	MS, SERVICES, OR AC	TIVITIES.
OR TTY Maine Relay 711.	TE POP	MAIL FOR FURTHER ASSI	STANCE, CO.	HIAUT IN	-	MINE WORKERS (COMPEN	art non t	BUPANU, A	CA COORDINATOR, 11	LEPTIONE: 1-000-001-000/
WCB-1 (eff. 1/1/13)											

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE, WCB-1

General Reporting Requirements

When any employee has reported to an employer under this Act any injury arising out of and in the course of the employee's employment that has caused the employee to lose a day's work, or when the employer has knowledge of any such injury, the employer shall report the injury to the board within 7 days after the employer receives notice or has knowledge of the injury. See Section 303.

The definition of a day for the purposes of filing a FROI under Section 303 is the wages in an employee's regular workday. Wages in an employee's regular workday is the amount equivalent to a day's wages for those who earn the same amount each workday, regardless of the duration of such person's employment. For all others, wages in an employee's regular workday is determined by dividing the pre-tax wages earned by the employee during the four (4) full work week period immediately preceding the date of injury by the number of days worked during the same four (4) full work week period. In the event that an employee has worked for less that the four (4) full work week period preceding the date of injury, wages in an employee's regular workday is determined by dividing the pre-tax wages earned by the number of days worked. See Rule 3.1.

Lost Wages: The FROI must be filed* within seven (7) days after the employer's notice or knowledge that an employee has actually lost wages in an amount equivalent to that sum which would have been earned in a regular workday.

Lost Time: If the employee has physical limitations due to the injury and loses consecutive hours equal to a regular workday because the employer cannot accommodate those restrictions, a FROI must be filed* within seven (7) days after an employer's notice or knowledge that an employee has actually lost hours equal to a regular workday regardless of actual wage loss.

When an employee loses a day or more from work that does not result in the filing of a Memorandum of Payment or a Notice of Controversy, the employer/insurer shall notify the Board of the employee's return to work date, if the date was not included on the original First Report, by filing* an 02 First Report using the IAIABC Claims Release 3 format. The employee's return to work date shall be filed within seven (7) days of the employee's return to work. See Rule 8.16.

Death: If the employee dies as a result of a job-related injury or if the employee dies at the work site, regardless of the reason for death, the employer/insurer must file* a FROI.

6

^{*} accepted EDI transaction, with or without errors (TE or TA only)

Medical Only: The employer/insurer must complete a FROI within seven (7) days of notice or knowledge of an employee injury that requires the services of a health care provider, but there is no obligation to file it with the Board unless the injury later causes the employee to lose a day's work. If the employer/insurer disputes a medical bill on a claim for which a FROI was never filed, the employer/insurer must file the FROI.

Two Injuries on Same Day at Same Employer: In the event that an employee alleges two separate injuries on the same date while working for the same employer, only one FROI may be filed via EDI. The other FROI must be sent to the Board (in accordance with the guidelines established above) via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board 27 State House Station Augusta, ME 04333-0027

Please call 207-287-7197 before sending the paper FROI so that it does not get rejected.

_

^{*} accepted EDI transaction, with or without errors (TE or TA only)

EDI Reporting Requirements

Unless a waiver has been granted, effective July 1, 2005, all FROIs (see above exception for two injuries on same day at same employer) shall be filed* using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format. See Rule 3.4. Following is a general overview. More detailed information can be found at: http://www.state.me.us/wcb/departments/technology/electronic.htm.

Each transaction requires a Maintenance Type Code (MTC/DN0002). MTC/DN0002 is a code that identifies the type of FROI transaction:

MTC	Definition
00	Original: The original/initial FROI, including the re-transmission of a FROI that was rejected due to a critical error, or a FROI that was previously cancelled.
01	Cancel: Cancel/delete FROI from the Board's system. The original/initial FROI was sent in error. The jurisdiction claim number/WCBN is mandatory for this transaction.
02	Change/Update: Change/update FROI. The jurisdiction claim number/WCBN is mandatory for this transaction.
СО	Correction: Correct transaction reported on the AKC as TE (see below). This transaction must contain the Maintenance Type Correction Code (MTCC) and Maintenance Type Correction Code Date (MTCC Date) fields. These fields communicate which report is being corrected. The jurisdiction claim number/WCBN is mandatory for this transaction.
04	Full Denial: A FROI 04 transaction indicates an original/new FROI and the filing of a Full Denial simultaneously. This MTC can only be used if the FROI has never been filed with the Board.
AQ	Acquired Claim: Report that a new claim administrator has acquired the claim. The jurisdiction claim number/WCBN is mandatory for this transaction.
AU	Acquired/Unallocated Claim: The equivalent of a FROI 00 filed by new claim administrator.
UR	Upon Request: Submitted in response to a specific request. If the Board receives a subsequent report of injury (MOP, Petition) for an employee for a date of injury that is not in the Board's system, a letter will be sent to the claim administrator requesting that a FROI UR be sent. There is no other circumstance in which a FROI UR should be sent to the Board. The jurisdiction claim number/WCBN is mandatory for this transaction.

^{*} accepted EDI transaction, with or without errors (TE or TA only)

Each transaction requires a Claim Type Code (DN0074). DN0074 is a code representing the current classification of the claim:

<u>DN0074</u> M	<u>Definition</u> Medical Only.
I	Lost Time/Indemnity.
N	Notification Only.
В	Became Medical Only.
L	Became Lost Time/Indemnity.

Each transaction is acknowledged with an Application Acknowledgement Code (DN0111) used to identify the accepted/rejected status of the transaction being acknowledged:

<u>DN0111</u> HD	<u>Definition</u> Batch Rejected: Batch rejected in its entirety.
TA	Transaction Accepted: The transaction was accepted without errors.
TE	Transaction Accepted with Error: An error was found on an expected data element. A CO (Correction) must be submitted to resolve the error(s).
TN	Transaction Rejected by Service Provider: The transaction fails mandatory requirements.
TR	Transaction Rejected: The transaction was not accepted. An error was found on a mandatory or mandatory conditional data element. A review of the error(s) must take place to determine if the transaction should be resubmitted with the same MTC – correcting the error. If an error of duplicate transaction, invalid event sequence, etc. then resubmission may not be required.

It is the claim administrator's responsibility to maintain the Acknowledgment (AKC) for every batch of EDI transactions sent to the Board. A FROI is not considered filed with the Board until it receives a TA or TE code on the AKC.

Corrections

Changes and corrections to FROIs must be filed* via EDI. Please note the important difference between a change (MTC 02) and a correction (MTC CO), as outlined above.

^{*} accepted EDI transaction, with or without errors (TE or TA only)

Distribution

WCB-1 (1/02) shall be mailed to the employee and the employer within 24 hours after the FROI is sent to the Board.

Closure (required for all lost time FROIs)

Closure of the FROI is required if a FROI is or should have been filed with the Board under Section 303. See Rule 8.16. Closure occurs when one of the following actions is taken:

- 1) Return to Work: Where days lost is less than or equal to 7 days, the actual return-to-work date must be reported to the Board within 7 days of the employee's return to work by sending a FROI 02 transaction. This step is unnecessary if the actual return-to-work date was previously reported on the original/initial FROI.
- 2) Indemnity Payment: Where the initial claim for indemnity benefits is paid, a Memorandum of Payment must be sent to the Board on or before the 14th day payment is due under Section 205(2) and must be received at the Board by the 17th day (three mail days are provided for receipt by the Board where sent via standard mail).
- 3) Controversy: Where the initial claim for indemnity benefits is in dispute, a Notice of Controversy must be filed* on or before the 14th day payment is due under Section 205(2).

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

INSTRUCTIONS FOR COMPLETING EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE, WCB-1

For instructional purposes, this Forms Manual indicates the WCB-1 Box # and description as listed on the paper form, the IAIABC Data Element Number (DN) and the data requirements of each field to assist claim administrators with electronic filing and paper distribution of FROIs. Specific technical questions can be answered by reviewing the Element Requirement Tables that are available at: http://www.state.me.us/wcb/departments/technology/edirule.htm.

Certain fields are mandatory at the time of the EDI transaction. If any mandatory fields are missing, incomplete or incorrect, the EDI transaction will completely reject, resulting in a TR on the AKC. A TR on the AKC means that the EDI transaction was completely rejected. The fatal error(s) that caused the rejection must be corrected and a new EDI transaction must be sent as if it had never sent it in before. Other fields are given an expected rating which indicates that the data in those fields is expected by the Board. If any expected fields are missing, incomplete or incorrect, the FROI will be accepted (filed) with errors. The error(s) must be corrected by submitting a MTC CO using the jurisdiction claim number/WCBN provided in the acknowledgement report.

-

^{*} accepted EDI transaction, with or without errors (TE or TA only)

1.	Ma	CB File Number (if known): (Assigned for FROI 00, FROI 04, and FROI AU; and to for FROI 01, FROI 02, FROI CO, FROI AQ and FROI UR) N5 – JURISDICTION CLAIM NUMBER) Enter the file number assigned by the Board to identify this claim.
1a.	OS	HA 300 Case Number (if applicable): (Not on the IAIABC format).
2a.		Lost Time - One or More Days
		Check this box if the employee has lost a day or more (DN74 - CLAIM TYPE CODE = I or L). If this box is checked, then 2b must be completed.
2b.		as Employee Paid for ½ Day or More on Day of Injury? The second of the IAIABC format is the second of the IAIABC format
3.		Lost Earnings But No Lost Time Check this box if the employee's earnings have been reduced because of the effects of this injury, but the employee has not lost a day's work or more (Not on the IAIABC format).
4.		Medical/Health Care Check this box if the employee's injury has required the services of a healthcare provider (DN74 - CLAIM TYPE CODE=B or M).
5.		Fatality Date of Death: Check this box if the employee has died as a result of a job-related injury or if the employee died at the work site (DN146 – DEATH RESULT OF INJURY CODE=Y or U). If this box is checked, the date of the employee's death is mandatory (DN57 – EMPLOYEE DATE OF DEATH).
6a.		Occupational Disease Check this box if the employee's occupational injury, illness or death is one of the following: loss of hearing, silicosis, asbestos-related disease, or exposure to radioactive properties. (DN290 – TYPE OF LOSS CODE=02). If this box is checked, then 6b and 6c must be completed.
6b.	Da	the of Last Exposure: Do not complete this box if 6a is not checked. If box 6a is checked, enter the last date that the employee was exposed to the cause or condition from which the occupational disease arose (DN31 – DATE OF INURY).
6c.	Da	te of Diagnosis as Occupationally Related: Do not complete this box if 6a is not checked.) If box 6a is checked, enter the date the injury, illness, or death was first diagnosed by a physician as being occupationally related. (Not on the IAIABC format)
7a.		Correct Prior Report Check this box if you are correcting a prior report (DN2 – MAINTENANCE TYPE CODE – 02 or CO) If this box is checked, then 7b and 7c must be completed

7b. Date of Correction: **Do not complete this box if 7a is not checked.**

If box 7a is checked, enter the date that this form was corrected

(DN3 – MAINTENANCE TYPE CODE DATE)

7c. Date correction Sent to WCB: **Do not complete this box if 7a is not checked.**

If box 7a is checked, enter the date that the corrected copy of this form was sent to the Board (**DN3** – **MAINTENANCE TYPE CODE DATE**)

8. State Employer Unemployment Insurance Account Number (UIAN): (Mandatory) (DN329 – EMPLOYER UI NUMBER)

Enter the UIAN of the employer where the employee was employed at the time of the injury. This 10-digit number is assigned by the Maine Department of Labor to all employers who are liable for contributions for unemployment insurance. If the employer is not liable for contributions to unemployment insurance, the employer will not have a UIAN and must, therefore, call the Coverage Division of the Board (287-7092) to ask for an identification number.

- 9. Federal Employer Identification Number (FEIN): (Expected) (DN16 EMPLOYER FEIN) Enter the FEIN of the employer where the employee was employed at the time of the injury. This 9-digit number is assigned by the Federal Internal Revenue Service (IRS) to report all monies paid to the IRS. In some cases, this is the same as the employer's social security number.
- 10. Employer Name: (Mandatory) (DN18 EMPLOYER NAME) Enter the legal name of the employer.
- 11. Street/P.O. Box Mailing Address:

DN168 – EMPLOYER MAILING PRIMARY ADDRESS (Expected)
DN169 – EMPLOYER MAILING SECONDARY ADDRESS (Expected Conditional)
Enter the primary and secondary (if applicable) mailing addresses of the employer.

12. City: (Expected) (DN165 – EMPLOYER MAILING CITY)

Enter the city of the employer's mailing address.

13. State: (Expected) (DN170 – EMPLOYER MAILING STATE CODE)

Enter the state of the employer's mailing address.

14. Zip: (Expected) (DN167 – EMPLOYER MAILING POSTAL CODE)

Enter the postal code of the employer's mailing address.

15. Telephone Number: (If Available) (DN159 – EMPLOYER CONTACT BUSINESS PHONE NUMBER)

Enter the phone number of the employer, including area code.

16. Primary Business Performed by Employer Where Injury Occurred: (**If Available**) (**DN25 – INDUSTRY CODE**)

Enter the code representing the nature of the employer's business which is contained in the industrial classification manual published by the Federal Office of Management and Budget.

- 17. Employer Location If Different from Mailing Address:
 - DN019 EMPLOYER PHYSICAL PRIMARY ADDRESS (Expected Conditional)
 - DN020 EMPLOYER PHYSICAL SECONDARY ADDRESS (If Available)
 - **DN021 EMPLOYER PHYSICAL CITY (Expected Conditional)**
 - **DN022 EMPLOYER PHYSICAL STATE CODE (Expected Conditional)**
 - **DN023 EMPLOYER PHYSICAL POSTAL CODE (Expected)**
 - **DN164 EMPLOYER PHYSICAL COUNTRY CODE (Expected Conditional)**

Values: see http://www.iaiabc.org/

Enter the employer's physical location if it differs from the employer's mailing address. If the employer has multiple locations, use the address for the place of business where the injured employee was working at the time of the injury.

18. Did Injury or Exposure Occur on Employer's Premises? (Mandatory) (DN249 – ACCIDENT PREMISES CODE) • Yes (DN249=E) • No (DN249=L or X)

If No, Then Give Name and Physical Address of the Employer Where the Employee was Injured or Exposed: (Expected Conditional)

- **DN120 ACCIDENT SITE ORGANIZATION NAME**
- **DN119 ACCIDENT SITE LOCATION NARRATIVE** (location not post office identifiable)
- **DN122 ACCIDENT SITE STREET**
- **DN121 ACCIDENT SITE CITY**
- **DN123 ACCIDENT SITE STATE CODE**
- DN033 ACCIDENT SITE POSTAL CODE
- DN118 ACCIDENT SITE COUNTY/PARISH
- DN280 ACCIDENT SITE COUNTRY CODE Values: see http://www.iaiabc.org/

If the employee was not injured on the employer's premises, then enter the name and physical address of the site where the employee was injured or exposed.

☐ Insurer	☐ Third-Party Administrator (TPA)	☐ Self-Administered Employer
Check the	box that describes the legal entity adjusting t	he claim.

19. Insurance/TPA Company Name: (Expected) (DN7 – INSURER NAME/DN188 – CLAIM ADMINISTRATOR NAME)

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim, and the legal name of the entity adjusting the claim.

20. Policy Number: (Not Applicable) (DN28 – POLICY NUMBER)

Enter the policy number identifying the coverage policy in effect for the claim.

21. Insurer File Number: (Mandatory) (DN15 – CLAIM ADMINISTRATOR CLAIM NUMBER)

Enter an identifier for a specific claim within the claim administrator's processing system.

22. Street/P.O. Box Mailing Address:

DN10 – CLAIM ADMINISTRATOR PRIMARY ADDRESS (Expected)

DN11 – CLAIM ADMINISTRATOR SECONDARY ADDRESS (If Available)

Enter the primary and secondary (if applicable) addresses of the claim administrator.

23. City: (Expected) (DN12 – CLAIM ADMINISTRATOR CITY)

Enter the city of the claim administrator.

24. State: (Expected) (DN13 - CLAIM ADMINISTRATOR STATE)

Enter the state of the claim administrator.

25. Zip: (Mandatory) (DN14 - CLAIM ADMINISTRATOR POSTAL CODE)

Enter the postal code of the claim administrator.

26. Telephone number: (Not on the IAIABC format)

Enter the telephone number, including area code, of the claim administrator.

27. Last Name:

(DN43 – EMPLOYEE LAST NAME) (Mandatory)

(DN255 – EMPLOYEE LAST NAME SUFFIX) (If Available)

Enter the employee's legally recognized last name and last name suffix.

28. First Name: (Mandatory) - (DN44 – EMPLOYEE FIRST NAME)

Enter the employee's first name.

29. MI: (If Available) (DN45 – EMPLOYEE MIDDLE NAME/INITIAL)

Enter the employee's middle initial.

30. Home Phone #: (If Available) (DN51 – EMPLOYEE PHONE NUMBER)

Enter the employee's home telephone number, including area code.

31. Social Security Number: (Mandatory)

Enter the employee's ID #.

Values: DN042 – EMPLOYEE SSN (DN270=S)

DN152 – EMPLOYEE EMPLOYMENT VISA (DN270=E)

DN153 – EMPLOYEE GREEN CARD (DN270=G)

DN154 – EMPLOYEE ID ASSIGNED BY JURISDICTION (DN270=A)

DN156 – EMPLOYEE PASSPORT NUMBER (DN270=P)

32. Gender: • Male • Female (Expected) (DN53 – EMPLOYEE GENDER CODE=M or F)

Check either M for Male or F for Female to identify the employee's gender (check neither if DN53=U).

33. Street/P.O. Box Mailing Address:

DN46 – EMPLOYEE MAILING PRIMARY ADDRESS (Expected) DN47 – EMPLOYE MAILING SECONDARY ADDRESS (If Available)

Enter the primary and secondary mailing addresses of the employee.

34. City: (Expected) – (DN48 – EMPLOYEE MAILING CITY)

Enter the city of the employee's mailing address.

35. State: (Expected) – (DN49 – EMPLOYEE MAILING STATE CODE)

Enter the state of the employee's mailing address.

36. Zip: (Expected) – (DN50 – EMPLOYEE MAILING POSTAL CODE)

Enter the postal code of the employee's mailing address.

37. Date of Birth: (Expected) – (DN52 – EMPLOYEE DATE OF BIRTH)

Enter the date employee was born.

38. Occupation/Job Title: (Expected) (DN60 - OCCUPATION DESCRIPTION)

Enter the employee's primary occupation at the time of injury, e.g., legal secretary, file clerk, computer programmer, truck driver, etc. Describe what the employee does as clearly as possible. Avoid using jargon.

39. Date of Hire: (Expected) – (DN61 – EMPLOYEE DATE OF HIRE)

Enter the date the employee began his/her employment with the employer under whose coverage the claim is being filed. If there have been multiple periods of employment with the same employer, this would be the beginning date of the current employment period.

40. Weekly Wage at Time of Injury (**If Available**) (**DN62 – WAGE**)

Enter the weekly wage the employee was receiving at the time of the injury.

- 41. Does Employee Work for Another Employer? Yes No (Not on the IAIABC format) Check either Yes or No.
 - If Yes, Give Name and Address:

Enter the name and address of any other employer(s) with whom the employee was employed at the time of the injury.

42. Date of Injury or Illness: (Mandatory) (DN31 – DATE OF INJURY)

For traumatic injury, enter the date on which the work-related accident occurred. For occupational disease or work-related cumulative injury, enter the date of last injurious exposure to the cause or substance creating the condition.

Date Employer Notified: (Expected) (DN40 – DATE EMPLOYER HAD KNOWLEDGE OF THE INJURY)

Enter the date that the employer had notice or knowledge of the work-related injury or illness.

43. Date of Incapacity: (Mandatory if DN74 – CLAIM TYPE CODE=I or L) (DN56 – INITIAL DATE DISABILITY BEGAN)

Enter the first day qualifying as a day of incapacity/disability in the first period or incapacity/disability.

Date Employer Notified: (Mandatory if DN74 – CLAIM TYPE CODE=I or L) (DN281 – DATE EMPLOYER HAD KNOWLEDGE OF DATE OF DISABILITY)

Enter the date that the employer had notice or knowledge of the work-related incapacity/disability in the first period or incapacity/disability.

In the case of sporadic incapacity, enter the date that the employer had notice or knowledge of a day or more collectively lost from work.

44. Time Employee Began Work: (Not on the IAIABC format)

Enter the time the injured employee's workday began on the day of the injury.

45. Date Employer Notified Insurer/TPA: (Expected) (DN41 – DATE CLAIM ADMINISTRATOR HAD KNOWLEDGE OF THE INJURY)

Enter the earlier of the date(s) the claim administrator or the insurer first received notice of the injury or illness from any source.

46. Time of Injury: (Mandatory) (DN32 – TIME OF INJURY)

Enter the time (military format) of the injury.

47. Has Employee Returned to Work? • Yes • No If box 2a is checked, check either Yes or No. (**Do not check this box if 2a is not checked.**) Check either Yes or No.

If Yes, Give Date: (**If Available**) (**DN68 – INITIAL RETURN TO WORK DATE**) Where days lost is less than or equal to 7 days, enter the first date on which the employee actually returned to work.

48. Specific Injury or Illness: (Expected) (DN35 – NATURE OF INJURY CODE)

Enter the title corresponding to the Nature of Injury Code.

Values: see http://www.iaiabc.org/

49. Body Part(s) Affected: (Expected) (DN36 – PART OF BODY INJURED CODE)

Enter the title corresponding to the Part of Body Injured Code.

Values: see http://www.iaiabc.org/

50. All Equipment, Materials, or Chemicals Employee was Using When the Event Occurred:

(Expected) (DN37 – CAUSE OF INJURY CODE)

Enter the title corresponding to the Cause of the Injury Code.

Values: see http://www.iaiabc.org/

51. Specify Activity the Employee was engaged in When the Event Occurred: (**Not on the IAIABC format**)

Enter a brief description of what the employee was doing at the time of the injury. For example: welding, mowing grass, cooking, typing, moving furniture, etc.

Was Activity Part of Normal Job Duties? • Yes • (Not on the IAIABC format) Check either Yes or No.

52. How Injury or Illness Occurred. Describe the Sequence of Events: (Expected) (DN38 – ACCIDENT/INJURY DESCRIPTION NARRATIVE)

Enter a free form description of how the accident occurred and the resulting injuries.

- 53. Hospitalized Overnight as Inpatient? Yes No (Not on the IAIABC format) Check either Yes or No.
- 54. Was the Employee Treated in an Emergency Room? Yes No (Not on the IAIABC format) Check either Yes or No.
- 55. Health Care Provider Name: (**Not on the IAIABC format**)

 Enter the name of the health care provider, if any, who provided initial medical treatment.
- 56. Mailing Address: (Not on the IAIABC format)

 Enter the address of the health care provided reported in Box 55, if applicable.
- 57. Telephone Number: (**Not on the IAIABC format**)

 Enter the telephone number, including area code, of the health care provider reported in Box 55, if applicable.
- 58. Preparer Name and Title: (**Not on the IAIABC format**) Enter the preparer's name and title.
- 59. Telephone Number: (**Not on the IAIABC format**)

 Enter the telephone number, including area code, of the preparer reported in Box 58.
- 60. Date Sent to WCB: (Mandatory) (DN100 DATE TRANSMISSION SENT)
 Enter the actual date the batch of data was sent via EDI to the Board.

NOTES

WAGE STATEMENT

STATE OF MAINE

WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:				6. SOCIAL SECURITY NUMBER (LAST 4 DIGITS):					7. WCB FILE NUMBER:				
2. EMPLOYER NAME:				XXX -XX- 8. EMPLOYEE LAST NAME:					9. FIRST NAME: 10. M.L.:			10. M.L:	
				8. EMPLOYEE LAST NAME:				9. FIRST NAME:		TU. M.L.:			
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:					11. ADDRESS-NUMBER AND STREET:								
4. INSURE	R NAME:			12. CITY:				13. STATE:		14. ZIP:	15. HOME PH		HONE:
5. INSURE	5. INSURER MAILING ADDRESS:				16. DATE OF INJURY:			17. DESCRIPTION OF INJURY:					
18. DOES EMPLOYEE WORK CONCURRENTLY FOR ANOTHER EMPLOYER? IF YES, GIVE NAME(S); NOTE: THE EMPLOYER SHALL SUBMIT A WAGE STATEMENT FOR EACH ADDITIONAL EMPLOYER.				YES U 19. DOES EMPLOYEE RECEIVE FRINGE B WHILE ON WORKERS' COMPENSATION? NO DETECTION WORKERS' COMPENSATION? NOTE: THE EMPLOYER SHALL RECALCUL WEEKLY WAGE IF/WHEN FRINGE BENEFI 1.5(2))					LATE THE AVERAGE NO				
	ST GROSS E	ARNINGS FOR EA			K:								
WK 1	WEEK ENDING	GROSS EARNINGS	19		WEEK	ENDING	GF	ROSS EARNINGS	WK 37	WEEK EN	DING	GROS	8 EARNINGS
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3			21						39				
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18 36			22.0					22. GR	GROSS AVERAGE				
23. COMMENTS: WEEKLY WAGE \$													
24. PREPARER NAME (TYPE OR PRINT):							25. TELEPHONE NUMBER:			26. DATE MAILED:			
E-MAI A	E-MAIL ADDRESS:					TOLL-FREE NUMBER:				MM DD 7777			~~

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.

WCB-2 (eff. 1/1/13)

WAGE STATEMENT, WCB-2

Reporting Requirements

The employer/insurer must file a Wage Statement within 30 days after the employer receives notice or has knowledge of a claim for compensation (box 22 of the Memorandum of Payment, WCB-3, or box 20 of the Notice of Controversy, WCB-9). See Section 303.

Distribution

A Wage Statement is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2 to the Employee Copy 3 to the Insurer Copy 4 to the Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation of Section 360(1). Violations will result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process the complaint in the manner set forth in Board Rule 15.9.

INSTRUCTIONS FOR COMPLETING WAGE STATEMENT, WCB-2

Identifying Information

- 1. Insurer File Number:
 - Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.
- 2. Employer Name:
 - Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.
- 3. Employer Mailing Address and Phone Number: Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home phone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

- 18. Does Employee Work Concurrently for Another Employer?

 Check Yes or No. If Yes, give name(s) of the concurrent employer(s). **NOTE: The**employer for whom the employee worked at the time of the injury is required to file the

 Wage Statement(s) from the employee's concurrent employer(s). See Section 205(8).
- 19. Does Employee Receive Fringe Benefits that may stop while on Workers' Compensation? Check Yes or No. NOTE: The employer shall recalculate the average weekly wage if/when fringe benefits cease. Per Section 102(4)(H), "Any fringe or other benefit paid by the employer that does not continue during the disability must be included for purposes of determining an employee's average weekly wage to the extent that the inclusion of the fringe or other benefit will not result in a weekly benefit amount that is greater than 2/3 of the state average weekly wage at the time of injury." The limitation does not apply if the injury results in the employee's death.

Wage Information

20. Weekly Wages

If the injured employee was employed seasonally (as defined by Section 102(4)(C)) at the time of injury, enter the employer's payroll week ending dates and the employee's corresponding gross earnings for the prior calendar year.

For all other types of employment, enter the employer's payroll week ending dates and the employee's corresponding gross earnings for the prior year. Week 52 is the payroll week that includes the date of injury. Week 1 is the payroll week from approximately one year prior to the injury.

A legible copy of the employer's record of payments (in support of the information reported in box 20) should be attached to the Wage Statement whenever possible.

Refer to Section 102(4) to determine additional filing requirements.

21. Total Earnings

Enter the total of gross earnings reported for weeks 1 through 52.

22. Gross Average Weekly Wage

Enter the average weekly wage in accordance with Section 102(4). See Appendix E for sample AWW calculations.

23. Comments

Use this space to provide any comments regarding the AWW calculation.

Preparer Information

24. Preparer Name (Type or Print):

Enter the preparer's name.

E-Mail Address:

Enter the preparer's email address.

25. Telephone Number:

Enter the preparer's telephone number, including area code.

Toll Free Number:

Enter the preparer's toll free telephone number if one is available.

Enter the date (month, day, year) this form is sent (mail, fax, email) to the Board. When revising a previously filed form, write "REVISED" across the top of the form, put a line through the original Date Sent to WCB date and note the revision date.

NOTES

SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT

STATE OF MAINE WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

EMPLOYER/INSURER COMPLETES BOXES 1	TO 17								
1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER			7. WCB FILE NUMBER:					
		XXX-XX-							
2. EMPLOYER NAME:	8. EMPLOYEE LAST N		9. FIRST NAME:	10. M.I.:					
3. EMPLOYER MAILING ADDRESS AND PHO	11. ADDRESS-NUMBE	R AND STE	REET:						
4. INSURER NAME:		12. CITY:		13. STATE:	144 70.	15. HOME F	HOME:		
4. INSURER NAME:		12. GIT:		13. 8 IAIE:	14. ZP:	15. HOME I	HONE:		
5. INSURER MAILING ADDRESS:		16. DATE OF INJURY:	7. DESCRIPT	DESCRIPTION OF INJURY:					
EMPLOYEE COMPLETES BOXES 18 TO 22									
18. FEI	DERAL	TAX FILING	STAT	rus					
SINGLE			MADO	NED/JOIN	-				
L SINGLE			MARK	aed/JUIN					
SINGLE/HEAD OF HOU	ISEHOI D		MARR	RIED/SEP/	ADATE				
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40									
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(IF NONE, SO STATE)	ATIONSHIP SE, DAUGHTER, SON)	DATE O BIRTH			SOCIAL SECURITY NUMBER				
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20. PREPARER NAME AND TITLE (TYPE OR PRINT	T):			21. TELB	HONE NUMBER:	22. DATE	WAILED:		
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THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY MAINE RELAY 711.

WCB-2A (eff. 1/1/13)

SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT, WCB-2A

Reporting Requirements

For dates of injury prior to 1/1/13, the employer or insurer (which can sometimes be one and the same) must file a Schedule of Dependent(s) and Filing Status Statement within 30 days after the employer's notice or knowledge of a claim for compensation (box 22 of the first Memorandum of Payment, WCB-3, or box 20 of the Notice of Controversy, WCB-9).

Distribution

The Schedule of Dependent(s) and Filing Status Statement is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2 to the Employee Copy 3 to the Insurer Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING SCHEDULE OF DEPENDENT(S) AND FILING STATUS STATEMENT, WCB-2A

Employer/Insurer Completes Boxes 1 To 17

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

Employee Completes Boxes 18 To 21

18. Federal Tax Filing Status

The employee checks the appropriate box based on the employee's Federal Income Tax Return. The filing status is determined according to IRS regulations for the year preceding the injury.

19. Dependent(s)

The employee lists all members of the employee's household whom the employee is able to claim as dependents on the Federal Income Tax Return. The Board will accept this form without the social security number(s) of dependent(s).

20. Preparer Name and Title:

The employee signs here.

21. Telephone Number:

The employee enters a telephone number where he/she can be reached.

22. Date Mailed:

The employee enters the date he/she completed the form.

NOTE: If the employee fails to (timely) complete boxes 18 through 21, then the employer/insurer can complete these boxes, based on any known filing status and dependent information. If the filing status and dependent information is unknown, we recommend a filing of "single with no dependents". The employer/insurer must document that the employee was contacted and failed to (timely) complete this section.

Upon receipt of the employee's version of the form, a copy should be forwarded to the Board along with any corresponding corrections (if applicable). The newly established weekly compensation rate is effective from the employee's date of injury.

NOTES

FRINGE BENEFITS WORKSHEET

STATE OF MAINE

WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER XXX-XX-	ER (last 4 digits):	7. WCB FILE NU	JMBER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME		10. M.L.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. EMPLOYEE ADDRESS-NO	JMBER AND STREE	ET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME F	PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION	OF INJURY:		

PROVIDE THE COST OF THE FRINGE BENEFIT PAID BY THE EMPLOYER AS OF THE EMPLOYEE'S DATE OF INJURY IF THE EMPLOYEE WAS RECEIVING THE BENEFIT ON HIS/HER DATE OF INJURY (SEE RULE CHAPTER 1(5)(1)).

NOTE: THE AMOUNTS REPORTED ARE SUBJECT TO VERIFICATION BY THE EMPLOYEE AND HIS/HER REPRESENTATIVE AND DOCUMENTATION MUST BE PROVIDED UPON REQUEST.

^{18.} Fringe Benefit	Provided	Continues while Employee is out of work	Date Benefits End	Weekly Cost of Benefits to Employer	
Health Benefits (inc. insurance)	Yes No	Yes No No		\$	
Dental Insurance	Yes No	Yes No No		\$	
Disability Insurance (inc. short and long term)	Yes No No	Yes No D		\$	
401K	Yes No	Yes 🗆 No 🗆		\$	
Life Insurance	Yes No C	Yes No D		\$	
Education/Training	Yes No No	Yes No No		\$	
Pension	Yes No	Yes No No		\$	
Other (please list):	Yes No 🗆	Yes No 🗆		\$	
Other (please list):	Yes No	Yes No		\$	
19. PREPARER NAME (TYPE OR F	RINT):		20. TELEPHONE NUMBER: () TOLL-FREE NUMBER:	21. DATE MALED:	

The State of Mains provides equal opportunity in employment and programs. Auxiliary sids and services are available to individuals with disabilities upon request. For essistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (886) 801-9087 or TTY Maine Relay 711.
WGB-28 (ef. 11/13)

FRINGE BENEFITS WORKSHEET, WCB-2B

Reporting Requirements

The employer/insurer must file a Fringe Benefits Worksheet within 30 days after the employer's notice or knowledge of a claim for compensation (box 22 of the first Memorandum of Payment, WCB-3, or box 20 of the Notice of Controversy, WCB-9). See Section 303.

Other Requirements

The employer shall recalculate the employee's average weekly wage when fringe benefits cease being paid by the employer. The employer must notify the insurer and the employee within seven (7) days when fringe benefits cease by filing an amended wage form, form WCB-2. The insurer or self-insured employer shall file the amended WCB-2 with the Board if it results in increased compensation to the employee. See Rule 1.5.2.B.

Distribution

The Fringe Benefits Worksheet is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2 to the Employee Copy 3 to the Insurer Copy 4 to the Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

INSTRUCTIONS FOR COMPLETING FRINGE BENEFITS WORKSHEET, WCB-2B

Employer/Insurer Completes Boxes 1 To 17

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

Fringe Benefit Information

18. Fringe Benefits

Provide the cost of the fringe benefit paid by the employer as of the employee's date of injury if the employee was receiving the benefit on his/her date of injury (see Rule 1.5.1).

NOTE: the amounts reported are subject to verification by the employee and his/her representative and documentation must be provided upon request.

Preparer Information

19. Preparer Name (Type or Print):

Enter the preparer's name.

E-Mail Address:

Enter the preparer's email address.

20. Telephone Number:

Enter the preparer's telephone number, including area code.

Toll Free Number:

Enter the preparer's toll free telephone number if one is available.

21. Date Sent to WCB: __/__/___

Enter the date (month, day, year) this form is sent (mail, fax, email) to the Board. When revising a previously filed form, write "REVISED" across the top of the form, put a line through the original Date Sent to WCB date and note the revision date.

NOTES

1. REVISION DATE: MM DD YYYY	ME	MORAND	UM OF I	PAYM	ENT		2. WCB FILE NUMBER (if known):
EMPLOYEE							
3. EMPLOYEE LAST NAME:	4. FIRST N	AME:		5. ML:	6. SOCIA		JMBER (last 4 digits):
7. STREET/P.O. BOX MAILING ADDRESS:	8. CITY:			9. STATE:	10. ZIP:	1	1. HOME PHONE NUMBER:
12. DATE OF INJURY:	13. SPECIF	FIC INJURY OR ILLNESS	3:		14. BOD	Y PARTS (S) AF	
MM DD YYYY							
			PLOYER				
15. INSURER FILE NUMBER:	16. EMPLO	YER NAME:		17. EMPLOY	ER MAILI	NG ADDRESS A	ND PHONE NUMBER:
18. INSURER NAME:	19.INSURE	R MAILING ADDRESS /	AND PHONE NUM	BER:			
20. YOUR EMPLOYER/INSURER IS REQUIRED 1 IS MADE FOR THE FOLLOWING REASON:	TO FILE THE		O EMPLOYEE SATION FORM UP		OF A LOS	ST TIME WORK-	RELATED INJURY, PAYMENT
A. YOUR CLAIM IS ACCEPTED.							
B. THIS IS A VOLUNTARY PAYMENT PE							
C. THIS IS A MANDATORY PAYMENT P	URSUANT T	O RULE 1.1. AMOUNT F	PAID \$	PER	SIOD COVE	ERED BY MAND	ATORY PAYMENT:
FROM (DATE CLAIM MADE) MM	DD YYYY	THROUGH (DATE NO	TICE OF CONTRO	VERSY FILED	AND BEN	EFITS PAID)	MM DD YYYY
21. TYPE OF PAYMENT:						2. FIRST DAY OF	F COMPENSABILITY AFTER WAS MET:
B. SPECIFIC LOSS: WEEKS							
C. OTHER (EXPLAIN):						MM	DD YYYY
					_	-	
23. DATE OF INCAPACITY://		E CHECK MAILED:	25. AVERAGE W	EEKLY WAGE		S. CURRENT WE	EEKLY COMPENSATION RATE:
DATE EMPLOYER NOTIFIED OF INCAPACITY: MM DD YYYY	_	M DD 7777	5			F VARYING RAT	ES ARE BEING PAID, ENTER
27. IS THIS AN APPORTIONMENT CLAIM? Y		IENEO ANOMEO	THE FOLLOWING		T	HE WORD "VAR	YING")
OTHER DATE(S) OF INJURY INVOLVED:	8 LI NO	IF TES, ANSWER	THE FOLLOWING	с.			
OTHER INSURER(S) INVOLVED:							
	_						
EXPLAIN THE TERMS OF THE APPORTIONMEN	1:						
28. COMMENTS:							
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24 STONE ST, STE 102	106 HOGAL BANGOR	N RD ON	NE VAUGHN PL		MOLLISO	N WAY	62 ELM ST PORTLAND, ME
AUGUSTA, ME 04330-5220	04401-56	38 CAR	RIBOU, ME 04736		04240-77	777	04101-3061
(207) 287-2308 1-800-400-6854	(207) 941~ 1-800-400-		207) 498-6428 -800-400-6855		(207) 753- 1-800-400-		(207) 822-0840 1-800-400-6858
29. PREPARER NAME (TYPE OR PRINT):		30. TELEPHONE NUM				31. DATE MA	
		()					
E-MAIL ADDRESS:		TOLL-FREE NUMBER	Ė			ММ	DD 7777

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.

WC8-3 (eff. 1/1/13)

MEMORANDUM OF PAYMENT, WCB-3

Reporting Requirements

The employer/insurer must file a Memorandum of Payment (MOP) with the Board: (1) upon making the first payment of weekly compensation for incapacity due to occupational injury, disease, or death, (2) upon making payment to the Treasurer of Maine in case of the death of any employee when there is no person entitled to compensation, (3) upon making the first payment of weekly compensation for specific loss benefits, (4) upon making a payment of compensation for permanent impairment (pre 1993 claims only), (5) upon making a payment of compensation pursuant to a decision of the Board, (6) upon making a payment of compensation pursuant to Rule 1.1.2, or (7) once indemnity benefits would otherwise be payable after the seven-day wait period is met for cases involving salary continuation.

A MOP must be sent to the Board on or before the 14th day payment is due under Section 205(2) and must be received at the Board by the 17th day (three mail days are provided for receipt by the Board where the form is sent via standard mail). Evidence of timely mailing is a rebuttable presumption to a determination of noncompliance under Section 360(1).

Other Requirements

Compliance with the initial indemnity payment obligation exists when the check is mailed within the later of: 1) 14 days after the employer's notice or knowledge of incapacity or 2) the first day of compensability plus 6 days. If an employer continues to pay the employee's salary, payments are deemed timely for purposes of compliance if made consistent with the employer's usual payroll practice.

The employer/insurer must file a Wage Statement and a Fringe Benefits Worksheet within 30 days after the employer's notice or knowledge of a claim for compensation (box 22 of the first Memorandum of Payment, WCB-3). See Section 303.

Distribution

A MOP is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2 Employee Copy 3 Insurer Copy 4 Employer

Closure

Closure of all MOPs other than those issued pursuant to Rule 1.1.3 is required. Closure occurs when one of the following actions is taken:

- 1) File a Discontinuance or Modification of Compensation, WCB-4, when:
 - a. The employee has returned to work for the employer of injury and/or the employee's
 post-injury wages (from the employer of injury) equal or exceed his/her pre-injury
 AWW
 - b. The employee has returned to work for the employer of injury without restrictions or limitations (due to the injury for which benefits are being paid), according to the employee's treating health care providers and there are no conflicting medical records with respect to the lack of restrictions or limitations (due to the injury for which benefits are being paid)
 - c. Board decision (e.g. a mediation agreement, Consent Decree, Hearing Officer Decree, or Lump Sum Settlement)
- 2) File a Certificate of Discontinuance or Reduction of Compensation, WCB-8, when:
 - a. Indemnity benefits are suspended in accordance with Section 205(9)(B)(1)
- 3) File a Petition when:
 - a. Indemnity benefits are suspended in accordance with Section 205(9)(B)(2)

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

Other Violations

Failure to file a Notice of Controversy (denial) or pay benefits on or before the 14th day payment is due under Section 205(2) is a violation of Rule 1.1.1. This violation requires payment of benefits to the injured employee as set forth in Rule 1.1.2, which must be reported on a MOP, as required by Rule 1.1.3.

Failure to file a denial or pay benefits on or before 30 days after the 14th day payment is due under Section 205(2) requires a penalty payment to the injured employee, as set forth in Section 205(3).

INSTRUCTIONS FOR COMPLETING MEMORANDUM OF PAYMENT, WCB-3

1.	Revision Date:	/	/
		MM DD	YYYY

If you are amending any information on this form that has already been filed with the parties involved (Board, employee, insurer, employer), enter the date (month, day, year) that this amended form is sent to the parties.

2. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

Employee

3. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. Street/P.O. Box Mailing Address:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

8. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Home Phone Number:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. Specific Injury or Illness:

Enter the specific injury or illness as it was entered in box 48 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Body Part(s) Affected:

Enter body part(s) affected as it was entered in box 49 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Employer

15. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

18. Insurer/TPA Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim, and the legal name of the entity adjusting the claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

19. Insurer/TPA Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Notice to Employee

20. Your Employer/Insurer is required to file this Workers' Compensation form upon payment of a lost time work-related injury. Payment is made for the following reason:
 A. □ Your Claim is Accepted (payment with prejudice). Check box A if the employer/insurer is accepting the claim.
B. ☐ This is a Voluntary Payment Pending Investigation (payment w/out prejudice). Check box B if the employer/insurer plans to investigate the claim.
C. ☐ This is a Mandatory Payment Pursuant to Rule 1.1. Amount Paid \$
Period Covered by Mandatory Payment: From (Date Claim Made//_ MM DD YYYY Through (Date NOC filed/benefits paid)// MM DD YYYY
Check box C if payment is required pursuant to Rule 1.1. If the employer fails to comply with the provisions of Rule 1.1, the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date the claim is made in accordance with 39-A M.R.S.A. § 205(2) and in compliance with 39-A M.R.S.A. § 204. The employer may discontinue benefits under this subsection when both of the following requirements are met:
i. The employer files a Notice of Controversy; and
ii. The employer pays benefits from the date the claim is made. If it is later determined that the average weekly wage/compensation rate used to compute the payment due was incorrect, and the amount paid was reasonable and based on the information gathered at the time, the violation of Rule 1.1 is deemed to be cured.
21. Type of Payment:
A. ☐ Weekly Compensation (§212(1), 213(1) or former §54, 54-A, 54-B, 55, 55-A, 55-B)
B. □ Specific LossWeeks (§212(3))
C. Other (Explain)
Check the box that describes the reason for the payment.
If Specific Loss is checked, enter the number of weeks payable.
If Other is checked, enter a brief description of the type of payment, e.g. Permanent Impairment (pre 1993), Salary Continuation, decision, occupational deafness (§612), death of any employee when there is no person entitled to compensation (§355(14)(F)), etc.

Complete this box if (1) the current incapacity is subject to the seven-day waiting period provided by Section 204, or (2) this is the initial MOP for a firefighter claim. Otherwise, do not complete this box.

For non-firefighter claims, enter the first day of incapacity after the seven-day wait has been met. For firefighter claims, enter the date of incapacity reported in box 23. In the case of total incapacity, the seven-day waiting period is met when the employee is incapacitated for seven calendar days (regardless of salary continuation – see below).

In the case of partial incapacity, the seven-day waiting period is met when (1) an employee loses wages because of the injury which cumulatively equal or exceed the employee's preinjury AWW, or (2) an employee loses wages because of the injury that would otherwise require the insurer to pay one week of benefits.

For cases involving salary continuation, this calculation should be made as if the employee has lost the wage that is being continued during the time he or she is absent from work or when the employee misses time from work that equals the hours worked in a regular work week. See Appendix G for more information.

Initial MOP: Enter the initial date disability began in the initial period of disability as it was entered in box 43 of the Employer's First Report of Occupational Injury or Disease, WCB-1. (Occupational disease claims: enter the date of injury reported in box 12.)

Subsequent MOP: Enter the first qualifying day of disability in the current period of disability being paid.

Specific loss claims (initial or subsequent MOP): Enter the date of the specific loss.

Initial MOP: Enter the date that the employer had notice or knowledge of the work-related incapacity/disability in the first period or incapacity/disability as it was entered in box 43 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

Subsequent MOP: Enter the date that the employer had notice or knowledge of the first qualifying day of disability in the current period of disability being paid.

Specific loss claims (initial or subsequent MOP): Enter the date that the employer had notice or knowledge of the specific loss.

24. Date Check Mailed:	/		/
	MM	DD	YYYY

Enter the date payment was first mailed to the employee for the current incapacity. For cases involving salary continuation, enter the date the payroll check is mailed or delivered or the salary is deposited.

25. Average Weekly Wage:

Enter the employee's average weekly wage pursuant to Section 102(4). If estimated, please indicate.

26. Current Weekly Compensation Rate:

□ Total □ Partial S

Check the appropriate box to indicate whether payment is for total or partial incapacity. Also, enter the dollar amount of the current compensation rate or applicable maximum. (Rates are based on the law in effect at the time of the injury.) Enter "Varying" in place of the dollar amount for varying rates. For cases involving salary continuation, enter the compensation rate that would otherwise be paid or the applicable maximum.

27. Is This an Apportionment Claim?

If this claim has been apportioned with another work-related injury, check Yes; otherwise, check No. If Yes is checked, answer all questions asked about the apportionment:

Other Date(s) of Injury Involved:

Other Insurer(s) Involved:

Explain the Terms of the Apportionment:

28. Comments

Use this area to enter any additional information, explanations or clarifications.

For cases involving permanent impairment (pre 1993 claims only), include the permanent impairment rating, number of weeks, and the amount of permanent impairment benefits paid.

For cases involving salary continuation, enter the salary amount that is being paid and any additional partial workers' compensation benefits due under Section 213, as applicable.

Preparer Information

29. Preparer Name (Type or Print):

Enter the preparer's name.

E-Mail Address:

Enter the preparer's email address.

30. Telephone Number:

Enter the preparer's telephone number, including area code.

Toll Free Number:

Enter the preparer's toll free telephone number if one is available.

Enter the date (month, day, year) this form is sent (mail, fax, email) to the Workers' Compensation Board. If the form being sent is a revision of a previous form, maintain the original Date Sent to WCB date and enter the revision date in box 1.

NOTES

DISCONTINUANCE OR MODIFICATION OF COMPENSATION PURSUANT TO 39-A M.R.S.A. §205(9)(A)

STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:		6. SOCIAL SEC	URITY NUMBER	R (last 4 digits):	7. WCB FILE NUM	BER:	
		XXX-XX-					
2. EMPLOYER NAME:		8. EMPLOYEE	AST NAME:		9. FIRST NAME:		10. M.L.:
		I					
3. EMPLOYER MAILING ADDRESS AND	PHONE NUMBER:	11. ADDRESS-	NUMBER AND S	TREET:			
4. INSURER NAME:		12. CITY:		13. STATE:	14. ZIP:	15. HOME P	HONE:
				l			
S. INSURED MAINING ADDRESS.		45 5475 55 1		47 0500007			
5. INSURER MAILING ADDRESS:		16. DATE OF IN	WURY:	17. DESCRIPT	ION OF INJURY:		
				l			
PLEASE COMPLETE EI	THER THE SEC	TION FOR D	ISCONTINUA	ANCE OR MO	ODIFICATION,	BUT NOT	BOTH.
		DIRCO		ICE			
		DISCO	NTINUAN	NCE			
18. REASON FOR DISCONTINUANCE:							
RETURNED TO WORK FOR SAME	ENDLOVED		□ 9671101	HED TO WORK SO	OR SAME EMPLOYER		
REGULAR/FULL DUTY MEDICAL					VERAGE WEEKLY W	AGE	
BOARD DECISION		OTHER (EXPLAIN)					
19. PERIOD OF INCAPACITY:	20. WEEKLY COMPE	DATICAL DATE:	21. AMOUNT PA	NIP.	20 0476	FINAL PAYMEN	T MAILED
	20. WEEKLY COMPE	NATION IONIE	21. AMOUNT P	AU.	22. UKIE	THAL PATRICI	MALED.
FROM (DATE): TO: (RETURN DATE):							
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24. REASON FOR MODIFICATION:							
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28. COMMENTS:							
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AUGUSTA, ME	BANGOR, ME		TCH DR, STE 11	10 1	LEWISTON, ME		PORTLAND, ME
04330-5220 (207) 287-2308	04401-5638 (207) 941-4550		IBOU, ME 04736 207) 498-6428		04240-7777 (207) 753-7700		04101-3061 (207) 822-0840
1-800-400-6854	1-800-400-6856	1-	800-400-6855		1-800-400-6857		1-800-400-6858
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WCB-4 (eff. 1/1/13)

DISCONTINUANCE OR MODIFICATION OF COMPENSATION, WCB-4

Reporting Requirements

The employer/insurer files this form for such reasons as the discontinuance or modification of compensation pursuant to Section 205(9)(A) or 205(9)(B)(2), a Board decision, a mediation agreement, cost-of-living adjustments, Social Security offsets, and unemployment compensation offsets. **NOTE: This form is not used for discontinuances or reductions under Section 205(9)(B)(1).**

Returned to Work for Same Employer: Reductions and discontinuances pursuant to Section 205(9)(A) must be based on the employee's actual earnings, however, an employer/insurer may discontinue benefits regardless of the employee's actual earnings if: (i) the employee returns to work without restrictions or limitations, due to the injury for which benefits are being paid, according to the employee's treating health care providers; and (ii) there are no conflicting medical records with respect to the lack of restrictions or limitations due to the injury for which benefits are being paid. The Discontinuance or Modification of Compensation must be filed within 14 days after the employee returns to work or receives an increase in pay. See Rule 8.11.

Board Decision: When the employee's benefits are discontinued or modified in accordance with a decree, a Discontinuance or Modification of Compensation must be filed. See Rule 8.12.

Mediation Agreement: When the employee's benefits are discontinued or modified in accordance with a Mediation Agreement, a Discontinuance or Modification of Compensation must be filed within 14 days from the date of the agreement. See Rule 8.12.

Petition for Review: When the employee's benefits are discontinued or modified based on the amount of actual documented earnings paid to the employee after filing the petition, the employer/insurer shall file the actual documented earnings and form WCB-4 showing the adjustment that was made with the Board at the same time it files the Petition for Review. Thereafter, the employer/insurer shall, within 30 days after receipt of the actual documented earnings, file with the Board the actual documentation it has received along with form WCB-4. See Rule 8.15.3.

Other: When the employee's benefits are discontinued, reduced or modified for any other reason (cost-of-living adjustment, Social Security offset, unemployment offset, etc.), a Discontinuance or Modification of Compensation must be filed.

Distribution

A Discontinuance or Modification of Compensation is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2 to the Employee Copy 3 to the Insurer Copy 4 to the Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation of Section 360(1). Violations will result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process the complaint in the manner set forth in Rule 15.9.

INSTRUCTIONS FOR COMPLETING DISCONTINUANCE OR MODIFICATION OF COMPENSATION, WCB-4

Identifying Information

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury: Enter a brief description of the injury or illness.
Discontinuance
18. Reason for Discontinuance: ☐ Returned to Work for Same Employer (Regular/Full Duty Medical Release) ☐ Board Decision ☐ Returned to Work for Same Employer (Earning At/Above AWW) ☐ Other (Explain)
Check the box that describes the reason for discontinuing compensation. If Other is checked, provide a brief explanation for the discontinuance.
19. Period of Incapacity: From (Date): Enter the date this incapacity began. This date should be the same as box 23 (date of incapacity) of the Memorandum of Payment, WCB-3, for the current incapacity period.
To (Return Date): Enter the date this incapacity ended. NOTE: Enter only one period of incapacity in box 19 per form.
20. Weekly Compensation Rate: Enter the weekly compensation rate used for this period of incapacity. If varying rates were paid, enter the word "Varying". If more than one rate was used, enter the last rate used.
21. Amount Paid: Enter the total amount of weekly compensation paid for the period of incapacity reported in box 19. Do not reduce this total by the amount of any recoveries. For cases involving apportionment, do not include amounts paid to the "lead" carrier. For cases involving salary continuation, do not include amounts paid by the employer.
22. Date Final Payment Mailed: Enter the date the last weekly compensation payment for this period of incapacity was mailed to the employee.
23. Comments: Use this space to provide any comments.
Modification
24. Reason for Modification: ☐ Returned to Work for Same Employer (Modified Work/Duty) ☐ Board Decision ☐ Cost of Living Adjustment (Pre 1993 claims only)

☐ Max Rate Increase

	☐ Increased/Decreased Earnings with Same Employer ☐ Other (Explain)
	Check the box that describes the reason for modification. If Other is checked, provide a brief explanation for the modification.
25.	Old Compensation Rate: Enter the compensation rate prior to the change. If varying rates were paid, enter the word "Varying".
26.	New Compensation Rate: Enter the new compensation rate. If varying rates will be paid, enter the word "Varying".
27.	Effective Date of Modification: Enter the date the rate change took effect.
28.	Comments: Use this space to provide any comments.
Pre	eparer Information
29.	Preparer Name (Type or Print): Enter the preparer's name.
	E-Mail Address: Enter the preparer's email address.
30.	Telephone Number: Enter the preparer's telephone number, including area code.
	Toll Free Number: Enter the preparer's toll free telephone number if one is available.
31.	Date Sent to WCB:/

Enter the date (month, day, year) this form is sent (mail, fax, email) to the Board. When revising a previously filed form, write "REVISED" across the top of the form, put a line through the original Date Sent to WCB date and note the revision date.

NOTES

CONSENT BETWEEN EMPLOYER AND EMPLOYEE

STATE OF MAINE WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:		6. SOCIAL SEC	IRITY NUMBER		7. WCB FILE NU	IMBER-		
. Hoover Le House C		XXX-X		•				
2. EMPLOYER NAME:		8. EMPLOYEE LAST NAME:			9. FIRST NAME: 10.		10. M.I.:	
3. EMPLOYER MAILING ADDRESS AND	PHONE NUMBER:	11. ADDRESS+	IUMBER AND S	TREET:				
4. INSURER NAME:		12. CITY:		13. STATE:	14. ZIP:	14. ZIP: 15. HOME PHONE:		
5. INSURER MAILING ADDRESS:		16. DATE OF IN	JURY:	17. DESCRIPTION	ON OF INJURY:			
18. TERMS OF CONSENT:		l						
18A. DATE OF INCAPACITY:	188. AVERAGE WEED	LY WAGE:	18C. CURRENT V RATE: TOTAL	PARTIAL		PIFYES, GIVE N	RK FOR ANOTHER AME(S): NO	
18E. NEW COMPENSATION RATE:	18F. EFFECTIVE DATE O	F REDUCTION:	18G. EFFECTIVE	DATE OF DISCONTINU			_	
19.	NOTICE TO	EMPLOYEE	(Please re	ad and initi	al)			
BEFORE YOU SIGN THIS FORM, YOU YOU SIGN THIS FORM. A LIST OF TH						AT RIGHTS	YOU HAVE IF	
EMPLOYEE INITIALS:								
THIS FORM SHALL NOT BE USED FOR UNDER SECTION 205 (9)(B)(2).		NOTICE TO ORDER, AWARD			MPENSATION SCH	HEME WAS	ENTERED	
		CON	SENT					
20. WE AGREE TO THE TERMS LISTED IN FORM CREATES A PAYMENT WITHOUR REOPENING THE CLAIM WITHIN CER ADVOCATE IF ANY, AND THE EMPLOY	JT PREJUDICE, DOE TAIN TIME LIMITS. 1	S NOT CREATE HIS FORM MUST	A PAYMENT SO BE SIGNED B	CHEME, AND DO Y THE EMPLOYE	ES NOT PREVENT	TEITHER PA	RTY FROM	
EMPLOYEE SIGNATURE				DATE	_			
EMPLOYEE'S AUTHORIZED REPRESENTAT	TIVE SIGNATURE (IF AP	PLICABLE)		DATE	_			
EMPLOYER/INSURER OR AUTHORIZED REF	PRESENTATIVE SIGNAT	URE		DATE	_			
ASSISTANCE IS AVA	ILABLE AT THE N	AINE WORKE	RS' COMPEN	SATION BOAR	RD'S REGIONAL	L OFFICES		
AUGUSTA, ME 04330-5220 (207) 287-2308	BANGOR 106 HOGAN RD BANGOR, ME 04401-5638 (207) 941-4550 1-800-400-6856	ONE VAI 43 HATCH I CARIBOU (207) 4	IBOU UGHN PL DR, STE 110 , ME 04736 98-6428 00-6855	LEWIST 04240	BON WAY ON, ME 1-7777 53-7700	62 E PORTI 0410 (207)	TLAND ELM 8T .AND, ME 11-3061 822-0840 400-6858	
21. PREPARER NAME AND TITLE (TYPE OR	PRINT):			22. TELEPI	HONE NUMBER:	23. DATE	WAILED:	

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711. WCB-4A (eff. 1/1/13)

CONSENT BETWEEN EMPLOYER AND EMPLOYEE, WCB-4A

Reporting Requirements

Pursuant to Rule 8.18, the Consent Between Employer and Employee (WCB-4A) may be used when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity, or a modification, reduction or discontinuance in ongoing weekly incapacity benefits.

- The Consent Between Employer and Employee (WCB-4A) can not be used to reduce or discontinue benefits on a date that is subsequent to the date the parties sign the WCB-4A.
- The WCB-4A shall be signed by the employee, the employee's attorney or worker advocate, if any, and a representative of the employer/insurer.
- The parties may agree to the pre-injury average weekly wage or may agree to pay benefits based upon a provisional wage and reserve the issue of the pre-injury average weekly wage for later determination by the Board. In either event, the form shall also indicate whether the employee is receiving 100% of the benefits at issue for the designated period. If the employee is receiving less than 100% of the benefits at issue for the designated period, the form shall indicate the percentage of benefits that the employee is receiving.
- The employer or insurance carrier shall make compensation payments within 10 calendar days after the WCB-4A is signed by the parties.
- Signing the WCB-4A does not by itself create a compensation payment scheme.
- Upon request by any of the parties, the Consent Between Employer and Employee, WCB-4A, shall be reviewed within 14 calendar days by an agent at the Board's regional offices in order to answer any relevant questions prior to the employer and employee signing this form.
- The Consent Between Employer and Employee, WCB-4A, shall not be used when an ongoing order, award of compensation, or a compensation payment scheme is entered under Section 205(9)(B)(2).

Distribution

A Consent Between Employer and Employee is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2	to the Employee
Copy 3	to the Insurer
Copy 4	to the Employer

Form Filing Violations

The Deputy Director of Benefits Administration will refer abuses of the Consent Between Employer and Employee, WCB-4A, to the Workers' Compensation Abuse Investigation Unit.

Other Violations

The Payments Division will review the Consent Between Employer and Employee, WCB-4A, in order to verify that the agreed upon benefits were correctly determined.

INSTRUCTIONS FOR COMPLETING CONSENT BETWEEN EMPLOYER AND EMPLOYEE, WCB-4A

Identifying Information

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number

Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name

Enter the employee's last name as entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury

Enter a brief description of the injury or illness.

Terms of Consent

18. Terms of Consent

Enter the details/terms of the agreement between the parties. The terms shall indicate whether the employee is receiving 100% of the benefits at issue for the designated period. If the employee is receiving less than 100% of the benefits at issue for the designated period, the terms shall indicate the percentage of benefits that the employee is receiving.

18A. Date of Incapacity

Enter the date of the first day that will be compensated when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or the date of incapacity as entered in box 23 of the Memorandum of Payment, WCB-3 when the parties have agreed to a voluntary modification, reduction or discontinuance of compensation.

18B. Average Weekly Wage

Enter the average weekly wage as entered in box 25 of the Memorandum of Payment, WCB-3, or the average weekly wage as agreed upon by the parties, if applicable.

18C. Current Weekly Compensation Rate:	☐ Total	☐ Partial	\$	
Check the appropriate box to indicate v	vhether paymer	nt is for total or	partial incapa	acity and
enter the weekly compensation rate agr	reed upon by th	e parties when	the parties ha	ve agreed
to a voluntary payment of a retroactive	closed-end per	riod of incapaci	ty or the curre	ent weekly
compensation rate when the parties hav	ve agreed to a v	oluntary modif	ication, reduc	tion or
discontinuance of compensation.				

18D. Does Employee Work For Another Employer?

If the employee was employed by more than one employer at the time of the injury, check Yes; otherwise, check no.

If Yes, Give Name(s)

If the employee was employed by more than one employer at the time of the injury, enter the name of the other employer(s).

18E. New Compensation Rate

Use this box only when the parties have agreed to a voluntary modification or reduction in compensation. Enter the new compensation rate agreed upon by the parties. If varying rates will be paid, enter the word "Varying".

18F. Effective Date of Reduction

Use this box only when the parties have agreed to a voluntary modification or reduction in compensation. Enter the effective date of the modification or reduction, as agreed upon by the parties.

18G. Effective Date of Discontinuance

Use this box only when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or a voluntary discontinuance of compensation. Enter the effective date of the discontinuance, as agreed upon by the parties.

18H. Amount Paid

Use this box only when the parties have agreed to a voluntary payment of a retroactive closed-end period of incapacity or when the parties have agreed to a voluntary discontinuance of compensation. Enter the total amount of indemnity to be paid for the retroactive closed-end period of incapacity or for the period of incapacity being paid or discontinued by the agreement of the parties. **NOTE: Do not reduce this total by the amount of any recoveries. For cases involving apportionment, do not include amounts paid to the "lead" carrier. For cases involving salary continuation, do not include amounts paid by the employer.**

Notice To Employee

19. This box should be initialed by the employee to ensure that he/she has read the notice.

Consent

20. This area shall be signed by the employee, the employee's attorney or worker advocate, if any, and a representative of the employer/insurer before it may be accepted by the Board.

Preparer Information

21. Preparer Name and Title:

Type or print the preparer's name and title.

22. Telephone Number

Enter the preparer's telephone number, including area code.

23. Date Mailed:

Enter the date this form is sent this form is sent (mail, fax, email) to the Board.

NOTES

CERTIFICATE AUTHORIZING RELEASE OF BENEFIT INFORMATION

STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

PART I (COMPLETED BY EMPLOYER/INSURER)					
1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBE XXX-XX-	:R (last 4 digits):	7. WCB FILE NUMBE	ER:	
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:		10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND	STREET:			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PH	ONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION	ON OF INJURY:		
PART II (COMPLETED BY EMPLOYEE)					
THE NATURE AND AMOUNT OF BENEFITS I RECEIVED OR SOCIAL SECURITY ADMINISTRATION	_, AUTHORIZE THE EMPLOYE R AM RECEIVING FROM THE F		BTAIN WRITTEN INF	ORMATION IN	DICATING
EMPLOYEE BENEFITS PLAN		NUMBER AND STREET		- -	
		TY, STATE, ZP		-	
I UNDERSTAND THAT THE EMPLOYER/INSURER IS ENTITI PLAN INFORMATION PURSUANT TO 39-A M.R.S.A. §221(5) WORKERS' COMPENSATION INDEMNITY BENEFITS. THIS SIGNATURE:	AND THAT MY FAILURE TO C CERTIFICATE OF RELEASE IS	COMPLETE AND I	RETURN THIS REPOR	RT MAY AFFEC	CT MY
PART III (COMPLETED BY SOCIAL SECURITY ADMINISTRA	ATION OR EMPLOYEE BENEF	IT PLAN ADMINI	STRATOR)		
THE EMPLOYEE AUTHORIZES THE RELEASE OF BENEFIT INFORMATION TO THE EMPLOYER/INSUER:	INFORMATION PURSUANT TO	0 39-A M.R.S.A. 9	j221(5). PLEASE PRO	WIDE THE FOL	LOWING
EFFECTIVE DATE OF ELIGIBILITY:					
2. CURRENT GROSS MONTHLY AMOUNT:					
3. PERCENTAGE OF EMPLOYEE BENEFIT PLAN PAID BY					
 IF BENEFITS FROM THIS EMPLOYEE BENEFIT PLAN AI PLEASE EXPLAIN: 	RESUBJECT TO REDUCTION	BASED ON RECO	EIPT OF WORKERS C	COMPENSATIO	IN BENEFIIS,
5. COMMENTS:					
6. BENEFIT INFORMATION SENT TO THE EMPOYER/INSU	JRER ON:				
SIGNATURE:		DATE:			
PREPARER NAME (TYPE OR PRINT):		TELEPHON	NE NUMBER:		

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711. WCB-6 (eff. 1/1/13)

CERTIFICATE AUTHORIZING RELEASE OF BENEFIT INFORMATION, WCB-6

Reporting Requirements

The employer/insurer may use the Certificate Authorizing Release of Benefit Information to request information about payments made to an injured employee for one of the following:

- Old-age insurance under the United States Social Security Act, 42 United States Code, Sections 301 to 1397f.
- An employer-funded self-insurance plan.
- An employer-funded wage continuation plan.
- An employer-funded disability insurance policy.
- An employer established or maintained pension plan or program.
- An employer established or maintained retirement plan or program.

The employer/insurer must complete Part I and have the injured employee complete Part II (release of information) before submitting the form to the Social Security Administration or other party who provides one of the above-listed employee benefit plans for completion of Part III.

INSTRUCTIONS FOR COMPLETING CERTIFICATE AUTHORIZING RELEASE OF BENEFIT INFORMATION, WCB-6

Part I Employer/Insurer Completes Boxes 1 Through 17

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

Part II Employee Completes This Section

Part III Social Security Administration or Employee Benefit Plan Completes This Section

NOTES

CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION PURSUANT TO 39-A M.R.S.A. §205(9)(B)(1)

STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

XXX-XX-

8. EMPLOYEE LAST NAME:

6. SOCIAL SECURITY NUMBER (last 4 digits): 7. WCB FILE NUMBER:

9. FIRST NAME:

10. M.I.:

1. INSURER FILE NUMBER:

2. EMPLOYER NAME:

3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND S	TREET:				
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME P	HONE:	
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIP	TION OF INJURY:	•		
NOTICE TO EMPLOYEE YOUR WEEKLY COMPENSATION BENEFITS WILL BE DISCONTINUED OR REDUCED 21 DAYS FROM THE DATE THIS CERTIFICATE WAS MAILED BASED ON THE ATTACHED INFORMATION. IF YOU DISAGREE WITH THIS ACTION, YOU MAY FILE A PETITION FOR REVIEW AND REQUEST REINSTATEMENT OF YOUR BENEFITS PENDING HEARING, UNDER 39-A M.R.S.A. §205(9)(C). YOUR PETITION AND REQUEST (ON FORM WCB-121) MUST BE MAILED TO THE WORKERS' COMPENSATION BOARD ADDRESS ABOVE.						
18. REASON FOR DISCONTINUANCE OR REDUCTION (IV	IUST ATTACH SUPPORTING DOC	UMENTATION	0:			
	DISCONTINUANCI	F				
19. PERIOD OF INCAPACITY: 20. V FROM (DATE):	VEEKLY COMPENSATION RATE:			22. COMPENS BE PAID FOR PERIOD:		
TO (EFFECTIVE DATE OF DISCONTINUANCE):						
	REDUCTION					
23. OLD COMPENSATION RATE: 24. NEW C	OMPENSATION RATE:		25. EFFECTIVE (DATE OF REDU	CTION:	
ASSISTANCE IS AVAILABLE AT THE	MAINE WORKERS' COMPEN	ISATION BO	ARD'S REGION	IAL OFFICES		
AUGUSTA BANGOR	CARIBOU		LEWISTON	PO	RTLAND	
24 STONE ST, STE 102 106 HOGAN RD AUGUSTA, ME BANGOR, ME	ONE VAUGHN PL 43 HATCH DR, STE 110		MOLLISON WAY EWISTON, ME		ELM ST LAND, ME	
04330-5220 04401-5638	CARIBOU, ME 04736		04240-7777	041	01-3061	
(207) 287-2308 (207) 941-4550 1-800-400-6854 1-800-400-6856	(207) 498-6428 1-800-400-6855		207) 753-7700 -800-400-6857		822-0840 1-400-6858	
26. PREPARER NAME (TYPE OR PRINT):	27. TELEPHONE N				AALED (MUST	
and the same of the same of				MATCH PO		
F. 1111 4 1999 F. 10	()					
E-MAIL ADDRESS:	TOLL-FREE NUMB	EK		MM DD	₩	
The State of Maine provides equal opportunity in en						
disabilities upon request. For assistance with this Telephone: 1-888-801-9087 or TTY Maine Relay 711. WCB-8 (eff. 1/1/13)		ordinator at 1	the Maine Work	kers' Compen	sation Board.	

CERTIFICATE AUTHORIZING RELEASE OF UNEMPLOYMENT INFORMATION, WCB-7

Reporting Requirements

The Certificate Authorizing Release of Unemployment Information may be used to request information about unemployment benefits made to an injured employee.

The requesting party must complete Part I and have the injured employee complete Part II (release of information) before submitting the form to the Workers' Compensation Board.

INSTRUCTIONS FOR COMPLETING CERTIFICATE AUTHORIZING RELEASE OF UNEMPLOYMENT INFORMATION, WCB-7

Part I Requestor Completes Boxes 1 Through 17

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

Part II Employee Completes This Section

Part III For Board Use Only

NOTES

CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION PURSUANT TO 39-A M.R.S.A. §205(9)(B)(1)

STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

XXX-XX-B. EMPLOYEE LAST NAME:

6. SOCIAL SECURITY NUMBER (last 4 digits): 7. WCB FILE NUMBER:

1. INSURER FILE NUMBER:

2. EMPLOYER NAME:

MPLOYER MAILING ADDRESS AND PHONE NUMBER: 11. ADDRESS-NUMBER AND STREET:						
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME P	U/ME-	
4. INOURER INVIIE.	12.0111.	IS. OINIE.	14.21	IS. HOME P	HONE.	
		l				
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPT	DESCRIPTION OF INJURY:			
		l				
NOTICE TO EMPLOYEE						
YOUR WEEKLY COMPENSATION BENEFITS WILL BE DISCONTINUED OR REDUCED 21 DAYS FROM THE DATE THIS						
CERTIFICATE WAS MAILED BASED ON THE ATTACHED INFORMATION. IF YOU DISAGREE WITH THIS ACTION, YOU MAY FILE A DETITION FOR BOUSTON, AND BEGULET, DELIVERY THE MAILED BENEFIT DE DESIGNATION FOR AND BASED AND BASED BENEFIT DESIGNATION FOR THE PROPERTY OF THE P						
A PETITION FOR REVIEW AND REQUEST REINSTATEMENT OF YOUR BENEFITS PENDING HEARING, UNDER 39-A M.R.S.A. 5205(9)(C). YOUR PETITION AND REQUEST (ON FORM WCB-121) MUST BE MAILED TO THE WORKERS' COMPENSATION						
BOARD ADDRESS ABOVE.						
18. REASON FOR DISCONTINUANCE OR REDUCTION (MUST ATTACH SUPPORTING DOCUMENTATION):						
DISCONTINUE						
DISCONTINUANCE						
19. PERIOD OF INCAPACITY: 20. W FROM (DATE):	20. WEEKLY COMPENSATION RATE: 21. C		ENSATION PAID 22. COMPENSATION TO BE PAID FOR 21 DAY			
		TE: PERIOD:				
TO (EFFECTIVE DATE						
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23. OLD COMPENSATION RATE: 24. NEW CO	OMPENSATION RATE:	25. EFFECTIVE DATE OF REDUCTION:				
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04330-5220 04401-5638	CARIBOU, ME 04736		04240-7777	04101-3061		
(207) 287-2308 (207) 941-4550	(207) 498-6428		07) 753-7700		822-0840	
1-800-400-6854 1-800-400-6856	1-800-400-6855	15	800-400-6857	1-800	H400-6858	
28. PREPARER NAME (TYPE OR PRINT): 27. TELEPHONE NUMBER:					ALED (MUST	
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E-MAIL ADDRESS:	TOLL-FREE NUMB	ER:		,	,	
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The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with						
disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board.						
Telephone: 1-888-801-9087 or TTY Maine Relay 711.						
WCB-8 (eff. 1/1/13)						

(21-DAY) CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION, WCB-8

Reporting Requirements

The employer/insurer must file a 21-Day Certificate of Discontinuance or Reduction of Compensation when compensation is discontinued or reduced pursuant to Section 205(9)(B)(1).

Reductions and/or discontinuances based on earnings when an employee returns to work with a different employer: When the employee's benefits are discontinued or modified based on the amount of actual documented earnings, the employer/insurer must include, with the 21-Day Certificate of Discontinuance or Reduction of Compensation, form 231-A (Employee's Return to Work Report). Within 14 calendar days after the expiration of the 21-day period, or within 14 days after receipt of documentation from the employee if the documentation is received after the expiration of the 21-day period, the employer/insurer shall file with the Board the documentation it has received along with an amended form WCB-8 which shall also include any necessary adjustments based on the documentation received by the employer/insurer.

A 21-day Certificate of Discontinuance or Reduction of Compensation must be sent **by certified mail** to the Board and to the employee (box 29).

Distribution

A Certificate of Discontinuance or Reduction of Compensation is a four-part form that is to be distributed as follows:

Copy 1 to the Board **via certified mail** at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2 to the Employee **via certified mail** no less than 21 days prior to the

effective date (box 19 or box 25) of the form.

Copy 3 to the Insurer Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING CERTIFICATE OF DISCONTINUANCE OR REDUCTION OF COMPENSATION, WCB-8

Identifying Information

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home phone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

18. Reason for Discontinuance or Reduction of Benefits:

Enter the reason for discontinuing or reducing compensation, and attach supporting documentation.

Discontinuance

19. Period of Incapacity:

From (Date):

Enter the date this period of incapacity began. This date should be the same as box 23 of the Memorandum of Payment, WCB-3, for the current incapacity period. **NOTE: Enter only one period of incapacity in box 19 per form.**

To (Effective Date of Discontinuance):

Enter the date payment for the incapacity will end (no earlier than 21 days from the date the Certificate of Discontinuance or Reduction of Compensation is mailed, box 29). Do not count the day the Certificate of Discontinuance or Reduction of Compensation is mailed to calculate the 21-day period.

EXAMPLE: May 5 (date certificate is mailed, box 29)

<u>+21</u> (days)

= May 26 (effective date of discontinuance)

20. Weekly Compensation Rate:

Enter the weekly compensation rate used for this period of incapacity. If varying rates were paid, enter the word "Varying". If more than one rate was used, enter the last rate used.

21. Compensation Payment to Date of Certificate:

Enter the total amount of weekly compensation paid to date (date the Certificate of Discontinuance or Reduction of Compensation is mailed) for the current incapacity period.

NOTE: Do not reduce this total by the amount of any recoveries. For cases involving apportionment, do not include amounts paid to the "lead" carrier. For cases involving salary continuation, do not include amounts paid by the employer.

22. Compensation to be Paid for 21-Day Period:

Enter the total anticipated amount of weekly compensation to be paid for the 21-day notice period.

Reduction

23. Old Compensation Rate:

Enter the compensation rate prior to change. If varying rates were paid, enter the word "Varying".

24. New Compensation Rate:

Enter the new compensation rate. If varying rates will be paid, enter the word "Varying".

25. Effective Date of Reduction:

Enter the date payment for the incapacity will be reduced (no earlier than 21 days from the date the Certificate of Discontinuance or Reduction of Compensation is mailed, box 29). Do not count the day the Certificate of Discontinuance or Reduction of Compensation is mailed to calculate the 21-day period.

EXAMPLE: May 5 (date certificate is mailed, box 29)

+21 (days)

= May 26 (effective date of reduction)

Preparer Information

26. Preparer Name (Type or Print):

Enter the preparer's name.

E-Mail Address:

Enter the preparer's email address.

27. Telephone Number:

Enter the preparer's telephone number, including area code.

Toll Free Number:

Enter the preparer's toll free telephone number if one is available.

Enter the date the Certificate of Discontinuance or Reduction of Compensation was mailed certified to the injured employee and the Board. This date should be 21 days prior to the effective date shown in box 19 (discontinuance) or box 25 (reduction) and match the postmark on the Certified Sender's Receipt.

NOTES

YOUR EMPLOYER/INSURER IS DEN'ING YOUR WORKERS' COMPENSATION CLAIMS RESOLUTION SPECIALIST THE NEAROSH FOR THE DENIAL IS CHECKED BELOW. IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW. 19a. FULL DENIAL REASON PARTIAL DENIAL REASON DATE OF INTIAL INCAPACITY		E OF CON					1. V	VCB FILE # (If known):
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The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711.

WCB-9 (eff. 1/1/13)

NOTICE OF CONTROVERSY (DENIAL), WCB-9

General Reporting Requirements

The employer/insurer must file * a Notice of Controversy (NOC) with the Board to report the denial of a claim for incapacity (disability), death and/or medical benefit(s).

Denial of Incapacity (disability) Benefits: Where the claim for incapacity (disability) benefits is in dispute, a NOC must be filed* on or before the 14th day payment is due under Section 205(2).

Denial of Death Benefits: Where the claim for death benefits is in dispute, a NOC must be filed* on or before the 14th day payment is due under Section 205(2).

Denial of Medical Benefits: Where the employee's claim is only for medical benefits, a NOC shall be filed* on or before the 30th day after notice or knowledge of the claim for medical benefits. See Rule 8.2 for exceptions and further instructions.

Other Reporting Requirements

The employer/insurer must file a Wage Statement and a Fringe Benefits Worksheet within 30 days after the employer's notice or knowledge of a claim for compensation (box 20 of NOC, WCB-9). See Section 303.

EDI Reporting Requirements

Unless a waiver has been granted, effective July 1, 2006, all denials and all MTC CO corrections to denials (that are the result of a TE transaction error) shall be filed* using the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Release 3 format. See Rule 3.4. Following is a general overview. More detailed information can be found at: http://www.state.me.us/wcb/departments/technology/electronic.htm.

Each transaction requires a Maintenance Type Code (MTC). The MTC is a code that identifies the type of transaction:

MTC Code	<u>Definition</u>
CO	Correction: Correct transaction reported on the AKC as TE (see below).
	This transaction must contain the Maintenance Type Correction Code
	(MTCC) and Maintenance Type Correction Code Date (MTCC Date)
	fields. These fields communicate which report is being corrected. The
	jurisdiction claim number/WCBN is mandatory for this transaction.
04	Full Denial: A FROI 04 transaction indicates an original/new FROI and
	the filing of a Full Denial simultaneously. This MTC can only be used if
	the FROI has never been filed with the Board.

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^{*} accepted EDI transaction, with or without errors (TE or TA only)

O4 Full Denial: A SROI 04 transaction indicates a Full Denial on a FROI that

has been previously filed with the Board. The jurisdiction claim

number/WCBN is mandatory for this transaction.

PD Partial Denial: A SROI PD transaction indicates a Partial Denial. The

jurisdiction claim number/WCBN is mandatory for this transaction.

If the claim is being denied in part, the FROI must be filed* prior to the submission of the Partial Denial. If the claim is being denied in full, the employer/insurer may file* a FROI 04 (the original FROI and Full Denial in one transaction).

Each transaction is acknowledged with an Application Acknowledgement Code (DN0111) used to identify the accepted/rejected status of the transaction being acknowledged:

<u>DN0111</u> HD	<u>Definition</u> Batch Rejected: Batch rejected in its entirety.
TA	Transaction Accepted: The transaction was accepted without errors.
TE	Transaction Accepted with Error: An error was found on an expected data element. A CO (Correction) must be submitted to resolve the error(s).
TN	Transaction Rejected by Service Provider: The transaction fails mandatory requirements.
TR	Transaction Rejected: The transaction was not accepted. An error was found on a mandatory or mandatory conditional data element. A review of the error(s) must take place to determine if the transaction should be resubmitted with the same MTC – correcting the error. If an error of duplicate transaction, invalid event sequence, etc. then resubmission may not be required.

It is the claim administrator's responsibility to maintain the Acknowledgment (AKC) for every batch of EDI transactions sent to the Board. A denial is not considered filed with the Board until it receives a TA or TE code on the AKC.

Corrections

Changes to NOCs filed prior to July 1, 2006 using a paper WCB-9 (10/98) must be made by sending an amended paper WCB-9 (10/98) to the Board via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board 27 State House Station Augusta, ME 04333-0027

PLEASE ENSURE THAT THE FORM IS CLEARLY MARKED AS AN AMENDMENT AND CIRCLE OR HIGHLIGHT THE INFORMATION TO BE CHANGED.

^{*} accepted EDI transaction, with or without errors (TE or TA only)

A MTC CO EDI transaction must be sent to the Board to correct any TE errors that were received on an acknowledgement report.

Changes/updates to denials that have been filed electronically (and are not the result of a TE transaction error) must be made by sending a paper WCB-9 (1/12/06) to the Board via e-mail, via fax (207-287-5895), or via standard mail at the following address:

Workers' Compensation Board 27 State House Station Augusta, ME 04333-0027

PLEASE ENSURE THAT THE FORM IS CLEARLY MARKED AS AN AMENDMENT AND CIRCLE OR HIGHLIGHT THE INFORMATION TO BE CHANGED.

Distribution

WCB-9 (1/12/06) shall be mailed to the employee, the employer and, if required by Rule 5.7.2 or Rule 8.2, the health care provider, within 24 hours after the denial is transmitted to the Board.

Closure

Closure of the denial is required. Closure occurs when one of the following actions is taken:

- 1) The employer or carrier withdraws the denial. This requires the filing of a Memorandum of Payment, WCB-3, when indemnity payments are made.
- 2) Denied benefit(s) are not pursued.
- 3) The parties reach agreement outside of the litigation process. This requires the filing of a Memorandum of Payment, WCB-3, or a Consent Between Employer and Employee form, WCB-4A, when the agreement includes indemnity payments.
- 4) The parties reach agreement at Mediation. This requires the filing of a Memorandum of Payment, WCB-3, when the agreement includes indemnity payments.
- 5) A petition is filed by the denied party after unsuccessful Mediation.

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process complaints in the manner set forth in Rule 15.9.

Other Violations

Failure to deny or pay benefits on or before the 14th day payment is due under Section 205(2) is a violation of Rule 1.1.1. This violation requires payment of benefits to the injured employee as set forth in Rule 1.1.2, which must be reported on a Memorandum of Payment, WCB-3, as required by Rule 1.1.3. Failure to deny or pay benefits on or before 30 days after the 14th day payment is due under Section 205(2) requires a penalty payment to the injured employee, as set forth in Section 205(3). Failure to deny or pay medical benefits within 30 days after receipt of notice of nonpayment by certified mail requires a penalty payment to the provider of the medical or health care services or the employee who paid for the medical or health care services, as set forth in Section 205(4).

INSTRUCTIONS FOR COMPLETING NOTICE OF CONTROVERSY, WCB-9

For instructional purposes, this Forms Manual indicates the WCB-9 Box # and description as listed on the paper form, the IAIABC Data Element Number (DN) and the data requirements of each field to assist claim administrators with electronic filing and paper distribution of denials. Specific technical questions can be answered by reviewing the Element Requirement Tables that are available at: http://www.state.me.us/wcb/departments/technology/edirule.htm.

Certain fields are mandatory at the time of the EDI transaction. If any mandatory fields are missing, incomplete or incorrect, the EDI transaction will completely reject, resulting in a TR on the AKC. A TR on the AKC means that the EDI transaction was completely rejected. The fatal error(s) that caused the rejection must be corrected and a new EDI transaction must be sent as if it had never sent it in before. Other fields are given an expected rating which indicates that the data in those fields is expected by the Board. If any expected fields are missing, incomplete or incorrect, the denial will be accepted (filed) with errors. The error(s) must be corrected by submitting a MTC CO using the jurisdiction claim number/WCBN provided in the acknowledgement report.

1. WCB File # (if known): (Assigned for FROI 04; Mandatory for SROI CO, SROI 04 and SROI PD) (DN5 – JURISDICTION CLAIM NUMBER)

Enter the file number assigned by the Board to identify this claim.

2. Employee Last Name:

(DN43 – EMPLOYEE LAST NAME) (Mandatory) (DN255- EMPLOYEE LAST NAME SUFFIX) (If Available)

Enter the employee's legally recognized last name and last name suffix.

- 3. First Name: (Mandatory) (DN44 EMPLOYEE FIRST NAME) Enter the employee's first name.
- 4. MI: (If Available) (DN45 EMPLOYEE MIDDLE NAME/INITIAL) Enter the employee's middle initial.
- 5. Employee ID: (Mandatory)

Enter the employee's ID type (**DN270 – EMPLOYEE ID TYPE QUALIFIER**)

Values: A= Employee ID Assigned by Jurisdiction (DN154)

E= Employee Employment Visa (DN152)

G=Employee Green Card (DN153)

P=Employee Passport Number (DN156)

S=Employee Social Security Number (DN42)

Enter the employee's ID #: (Expected)

DN042 - EMPLOYEE SSN

DN152 – EMPLOYEE EMPLOYMENT VISA

DN153 - EMPLOYEE GREEN CARD

DN154 – EMPLOYEE ID ASSIGNED BY JURISDICTION

DN156 – EMPLOYEE PASSPORT NUMBER

6. Street/P.O. Box Mailing Address: (Expected on FROI 04) (DN46 – EMPLOYEE MAILING PRIMARY ADDRESS)

Enter the employee's mailing address.

7. City: (Expected on FROI 04) (DN48 – EMPLOYEE MAILING CITY)

Enter the city of the employee's mailing address.

8. State: (Expected on FROI 04) (DN49 – EMPLOYEE MAILING STATE CODE)

Enter the state of the employee's mailing address.

9. Zip: (Expected on FROI 04) (DN50 – EMPLOYEE MAILING POSTAL CODE)

Enter the postal code of the employee's mailing address.

10. Home Phone #: (If Available) (DN51 – EMPLOYEE PHONE NUMBER)

Enter the employee's home telephone number, including area code.

11. Date of Injury: (Mandatory) (DN31 – DATE OF INJURY)

Enter the date of the employee's injury.

12. Specific Injury or Illness: (Expected on FROI 04) (DN35 – NATURE OF INJURY CODE)

Enter the title corresponding to the Nature of Injury Code.

Values: see http://www.iaiabc.org/

13. Body Part(s) Affected: (Expected on FROI 04) (DN36 – PART OF BODY INJURED CODE)

Enter the title corresponding to the Part of Body Injured Code.

Values: see http://www.iaiabc.org/

14. Insurer/Claim Admin File #: (Mandatory) (DN15 – CLAIM ADMINISTRATOR CLAIM NUMBER)

Enter an identifier for a specific claim within the claim administrator's processing system.

15. Employer Name: (Mandatory on FROI 04) (DN18 – EMPLOYER NAME)

Enter the legal name of the employer.

16. Employer Mailing Address and Phone #:

DN168 – EMPLOYER MAILING PRIMARY ADDRESS (Expected on FROI 04)

DN165 – EMPLOYER MAILING CITY (Expected on FROI 04)

DN170 – EMPLOYER MAILING STATE CODE (Expected on FROI 04)

DN167 – EMPLOYER MAILING POSTAL CODE (Expected on FROI 04)

DN159 – EMPLOYER CONTACT BUSINESS PHONE NUMBER (If Available)

Enter the primary mailing address, city, state, postal code, and phone number of the employer.

17. Insurer/Claim Admin Name: (Expected) (DN188 – CLAIM ADMINISTRATOR NAME) Enter the legal name of the entity adjusting the claim.

Insurer/Claim Admin Address:

DN10 – CLAIM ADMINISTRATOR PRIMARY ADDRESS (Expected on FROI 04)

DN12 – CLAIM ADMINISTRATOR CITY (Expected on FROI 04)

DN13 – CLAIM ADMINISTRATOR STATE CODE (Expected on FROI 04)

DN14 – CLAIM ADMINISTRATOR POSTAL CODE (Mandatory)

Enter the address, city, state, and postal code of the claim adjusting office handling the claim.

18. Insurer/Claim Admin FEIN: (Mandatory) (DN187 – CLAIM ADMINISTRATOR FEIN)
Enter the Federal Employer Identification Number of the entity licensed or allowed by a jurisdiction to adjust a claim.

19a. Full Denial Reason (Mandatory on FROI 04 and SROI 04) (DN198 – FULL DENIAL REASON CODE)

Enter the code(s) used to identify the reasons for denying a claim in its entirety. Values (Enter no more than five):

1=No Compensable Accident (A,B,C,D,E,F,G or H)

2=No Causal Relationship (A,B,C,D,E or F)

3=No Coverage (A,B,C,D,E,F,G or H)

4=Substance Use/Abuse (A)

5=Other (not elsewhere classified) (A or C)

Full Denial Effective Date (Mandatory on FROI 04 and SROI 04) (DN199 – FULL DENIAL EFFECTIVE DATE)

Enter the date from which the claim administrator is denying all benefits for the claim.

19b. Partial Denial Reason (Mandatory on SROI PD) (DN294 – PARTIAL DENIAL CODE)

Enter a code identifying which portion of the claim is being denied.

Values:

A=Denying Indemnity in Whole, not Medical

B=Denying Indemnity in Part, not Medical

C=Denying Medical in Whole, Not Indemnity

D=Denying Medical in Part, Not Indemnity

E=Denying Indemnity in Whole, Medical in Part

F=Denying Medical in Whole, Indemnity in Part

G=Denying Both Indemnity & Medical in Part

20a. Date of Initial Incapacity (Expected for Lost Time Claims) (DN56 – INITIAL DATE DISABILITY BEGAN)

Enter the first day qualifying as a day of disability in the first period of disability. If the period of disability has been intermittent or sporadic, please include comments in Box 21 (DN197).

Current Date of Incapacity (**If Applicable**) (**DN144 – CURRENT DATE DISABILITY BEGAN**)

Enter the first qualifying day of disability in the current period of disability being denied. If this date is the same as DN56, leave blank.

If the period of disability has been intermittent or sporadic, please include comments in Box 21 (DN197).

20b. Date Employer Notified (Mandatory for Lost Time Claims) (DN281 – DATE EMPLOYER HAD KNOWLEDGE OF DATE OF DISABILITY)

Enter the date that the employer was notified or had knowledge of the employee's work-related disability/incapacity (DN56 or DN144 as applicable to this transaction).

21. Comments: (If Applicable) (DN197 – DENIAL REASON NARRATIVE)

Use this area to enter any additional information, explanations or clarifications.

PLEASE INCLUDE THE NAME AND CONTACT INFORMATION OF THE HEALH CARE PROVIDER IF THE DENIAL IS CONTROVERTING WHETHER A HEALTH CARE PROVIDER'S BILL IS REASONABLE AND PROPER UNDER SECTION 206.

22. **IF THIS DENIAL NOTICE IS NOT TIMELY PURSUANT TO RULE 1.1,** the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date of incapacity in accordance with Section 205(2) and in compliance with Section 204. The requirement for payment of benefits under this subsection automatically ceases upon the filing of a denial and the payment of any accrued benefits.

23. Name: (Expected on SROI 04 and SROI PD) (DN140 – CLAIM ADMINISTRATOR CLAIM REPRESENTATIVE NAME)

Enter the name of the individual working for the claim administrator that is responsible for handling the claim.

E-Mail Address: (If Available) (DN138 – CLAIM ADMINISTRATOR CLAIM REPRESENTATIVE E-MAIL ADDRESS)

Enter the internet E-mail address of the individual responsible for handling the claim.

24. Telephone #: (If Available) (DN137 – CLAIM ADMINISTRATOR CLAIM REPRESENTATIVE BUSINESS PHONE NUMBER)

Enter the telephone number of the individual responsible for handling the claim.

25. Date Sent to WCB: (Mandatory) (DN100 – DATE TRANSMISSION SENT)

Enter the actual date the batch of data was sent via EDI to the Board.

NOTES

LUMP SUM SETTLEMENT

STATE OF MAINE

WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SEC	URITY NUMBER (I	est 4 digits):	7. WCB FILE NUM	BER:	
2. EMPLOYER NAME:	XXX-XX-	107 11115		a proting		45.141
2. EMPLOTER NAME:	8. EMPLOYEE LAST NAME: 9. FIRST NAME: 10. M.L.:			10. M.I.:		
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	PHONE NUMBER: 11. ADDRESS-NUMBER AND STREET:					
4. INSURER NAME:	12. CITY:		13. STATE:	14. ZIP:	15. HOME P	HONE:
5. INSURER MAILING ADDRESS:	16. DATE OF IN	JURY:	17. DESCRI	PTION OF INJURY:		
18. TYPE OF SETTLEMENT:						
STRUCTURED SETTLEMENT (ATTACH DOCUMENTATION)				TLEMENT OF SETTLEMENT	\$	
19. PERMANENT IMPAIRMENT RATING		6 AMOUN	IT PAID	\$		
SOURCE OF RATING		DATE OF F	RATING_			
20. EXPECTED FUTURE MEDICAL COSTS RELATI	ED TO THE IN.	URY: \$				
21. COMMENTS:						
22. EMPLOYER/INSURER REPRESENTATIVE (TYPERINT):	22. EMPLOYER/INSURER REPRESENTATIVE (TYPE OR PRINT): 23. EMPLOYEE REPRESENTATIVE (TYPE OR PRINT):					
	RELI	EASE				
24. EMPLOYEE/DEPENDENT:						
READ THIS FORM AND ALL ATTACHMENTS. I CO THE HEARING OFFICER, I RELEASE THE EMPLOY	I AM THE PERSON ENTITLED TO WORKERS' COMPENSATION BENEFITS ON ACCOUNT OF THIS INJURY OR DEATH. I HAVE READ THIS FORM AND ALL ATTACHMENTS. I CONSENT TO THE SETTLEMENT. WHEN THE SETTLEMENT IS APPROVED BY THE HEARING OFFICER, I RELEASE THE EMPLOYER AND INSURER NAMED ABOVE FROM ALL FURTHER LIABILITY FOR THIS INJURY, EXCEPT AS OTHERWISE APPROVED BY THE BOARD.					
EMPLOYEE/DEPENDENT SIGNATURE	DATE	EMPLOYEE RE	PRESENTAIV	E SIGNATURE	DAT	TE.
25. EMPLOYER/INSURER:						
THE EMPLOYER CONSENTS TO THE SETT	LEMENT:	YES NO		SIGNATURE		DATE
THE INSURER CONSENTS TO THE SETTLE	EMENT:	YES NO	-	SIGNATURE		DATE
		SION				
26. THE REQUESTED SETTLEMENT (IS/IS NO EMPLOYEE/DEPENDENT THE SETTLEMEN			LOYER/IN	ISURER IS OR		PAY THE AND ALL
OUTSTANDING COMPENSATION OBLIGATION MADE WITHIN 10 DAYS PURSUANT TO 39-A EMPLOYEE/DEPENDENT'S ATTORNEY A FEI THIS CLAIM ARE HEREBY DISMISSED.	ONS INCURR M.R.S.A. 324	ED PRIOR TO (1). THE EMP	LOYER/IN	ISURER IS OR	PAYMENT DERED TO	MUST BE
HEARING OFFICER SIGNAT	TURE		DAT	E		

The State of Maine provides equal opportunity in employment and programs. Auxiliary side and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at this Maine Workers' Compensation Board. Telephone: 1-888-801-8087 or TTY Maine Relay 711.
WCB-10 (ett. 1/1/13)

LUMP SUM SETTLEMENT, WCB-10

The employer/insurer, employee, and/or attorney files the Lump Sum Settlement form to request approval of a lump sum settlement.

A Lump Sum Settlement is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2 to the Employee Copy 3 to the Insurer Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING LUMP SUM SETTLEMENT, WCB-10

Identifying Information

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

Type of Settlement

18. Check the box that describes the type of settlement. If the settlement is structured, attach the appropriate documentation. If the settlement is a straight lump sum, enter the total value.

Permanent Impairment Rating

19. Enter the percentage of whole body permanent impairment rating, the amount paid, the source of the rating (Agreement of Parties, Decree, Mediation, Section 207 Exam, Section 312 Exam, or Treating Doctor), and the date of the rating.

Future Medical Costs

20. Enter the expected amount of future medical costs related to the injury.

Comments

21. Use this space to provide any comments.

Preparer Information

- 22. Employer/Insurer Representative

 Type or print the name of the employer/insurer representative.
- 23. Employee Representative

 Type or print the name of the employee representative.

Release

- 24. This box is for the employee/dependent and his/her representative to sign and date to consent to the lump sum settlement.
- 25. This box is for the employer/insurer and its representative (if applicable) to sign and date to consent to the lump sum settlement.

Decision

26. This box is to be used only by the Hearing Officer.

NOTES

STATEMENT OF COMPENSATION PAID

STATE OF MAINE

WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	R (last 4 digits):	7. WCB FILE NUM	BER:
	XXX-XX-			
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME: 9. FIRST NAME:			10. M.I.:
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND	STREET:		
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME PHONE:
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPTION	ON OF INJURY:	
18. REASON FOR REPORT: INTERIM REPORT (ONGOING PAYMENTS OF	ANY KIND) FINAL	REPORT (NO F	URTHER PAYM	ENTS ANTICIPATED)
	DAVMENT CHMM	IDV		
19. LIST CUMULATIVE TOTALS (DO NOT IN	PAYMENT SUMMA			
19. LIST COMULATIVE TOTALS (DO NOT IN	CLUDE ANT PENALIT A	MOUNTS):		
MEDICAL TREATMENT \$		NEFIT/FUNER (NOT TO EXC		\$
WEEKLY \$ COMPENSATION	LEGAL EXPENSE (EMPLOYEE \$ RELATED)			
PERMANENT \$ IMPAIRMENT (PRE 1993 ONLY)	LEGAL EXPENSE (EMPLOYER \$ RELATED)			
EMPLOYMENT \$ REHABILITATION	INTEREST AND OTHER PAYMENTS \$			\$
LUMP SUM SETTLEMENT \$				
TOTAL AMOUNT PAID \$ (DO NOT REDUCE THESE TOTALS BY THE AMOUNT OF ANY RECOVERIES, INCLUDING DEDUCTIBLES)				
ARRIGHANCE IS AVAILABLE AT THE	MAINE WORKERS! COMP	NEATION BO	DD'S DECION	I OFFICE
A\$\$I\$TANCE I\$ AVAILABLE AT THE AUGUSTA BANGOR 24 \$TONE \$T, \$TE 102 105 HOGAN RD AUGUSTA, ME BANGOR, ME 04330-5220 04401-5638 (207) 287-2308 (207) 941-4550 1-800-400-6854 1-800-400-6856	MAINE WORKERS' COMPL CARIBOU ONE VAUGHN PL 43 HATCH DR, STE 110 CARIBOU, ME 04736 (207) 499-6428 1-800-400-6855	26 MC LEV 04 (20	ARD'S REGIONA EWISTON ULLISON WAY VISTON, ME 4240-7777 7) 753-7700 00-400-6857	PORTLAND 62 ELM ST PORTLAND, ME 04101-3051 (207) 822-0840 1-800-400-6858
TO DOCUMENT WHILE CAME OF BOOKER.	34 75 55 10	NE MINDED		22 0475 144 55
20. PREPARER NAME (TYPE OR PRINT):	21. TELEPHO	NE NUMBER:		22. DATE MAILED:
E-MAIL ADDRESS:	TOLL-FREE NUMBER: MM DD YYYY			
The State of Maine provides equal opportunity in er	nployment and programs. A			

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711. WCB-11 (eff. 1/1/13)

STATEMENT OF COMPENSATION PAID, WCB-11

Reporting Requirements

The initial Statement of Compensation Paid, Interim Report (WCB-11) shall be filed with the Board within 195 days of the date of an injury where indemnity payments have been made, and as a Final Report when no further payments are anticipated. Subsequent Statements of Compensation Paid (WCB-11) shall thereafter be filed with the Board within fifteen (15) days of each anniversary date of an injury when payments of any type have been made since the previous Statement of Compensation Paid (WCB-11). The Statement of Compensation Paid (WCB-11) is required when only medical payments are made subsequent to the filing of a Final Report. There is no requirement to file the Statement of Compensation Paid on claims when payments are made for medical only services and no indemnity was ever paid on the claim. See Rule 8.1.

Distribution

A Statement of Compensation Paid is a four-part form that is to be distributed as follows:

Copy 1 Workers' Compensation Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2 Employee Copy 3 Insurer Copy 4 Employer

Form Filing Violations

Failure to file any Board-prescribed forms within established time frames is a violation under Section 360(1). Violations may result in the filing of complaints with the Abuse Investigation Unit. The Abuse Investigation Unit will process the complaint in the manner set forth in Rule 15.9.

INSTRUCTIONS FOR COMPLETING STATEMENT OF COMPENSATION PAID, WCB-11

Identifying Information

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the insurer name as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the insurer mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID # as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

Payment Summary

- 18. ☐ INTERIM REPORT (ONGOING PAYMENTS OF ANY KIND)
 - ☐ FINAL REPORT (NO FURTHER PAYMENTS ANTICIPATED)

Check the box that describes the type of report being filed.

19. List Cumulative Totals:

- Do not include any penalty amounts (<u>regardless of fault</u>).
- For cases involving apportionment, do not include amounts paid to the "lead" carrier.
- For cases involving salary continuation, do not include amounts paid by the employer.
- Do not reduce these totals by the amount of any recoveries, including deductibles.

<u>Medical</u> – enter the sum of medical, surgical and hospital services, nursing, medicines, and mechanical, surgical aids paid for this claim.

<u>Weekly Compensation</u> – enter the sum of indemnity benefits paid for this claim (NOTE: dependent benefits, benefits paid to the State resulting from the death of an employee when there is no person entitled to compensation, specific loss benefits, and mandatory payments are all considered weekly compensation benefits). When filing this form as a Final Report, this amount must match the sum of the Amount Paid on all WCB-4, WCB-4A and mandatory Memorandum of Payment forms and/or the sum of the Compensation Payment to Date of Certificate and Compensation to be Paid for 21-Day Period on all WCB-8 forms.

<u>Permanent Impairment</u> – enter the sum of permanent impairment benefits paid for this claim (pre 1993 claims only).

<u>Employment Rehabilitation</u> – enter the sum of employment rehabilitation expenses paid for this claim.

<u>Lump Sum Settlement</u> – enter the amount of any lump sum settlement approved by a Board Hearing Officer for this claim (include the amount of any Medicare Set-Aside).

<u>Death Benefit/Funeral Expense</u> – enter the sum of funeral expenses paid for this claim (cannot exceed \$7,000.00).

<u>Legal Expense (Employee Related)</u> – enter the sum of the claimant's legal expenses paid for this claim.

<u>Legal Expense (Employer Related)</u> – enter the sum of the employer's legal expenses paid for this claim.

<u>Interest and Other Payments</u> – enter the sum of interest and all other payments not otherwise reported for this claim.

<u>Total Paid</u> - enter the total amount paid for all categories.

EXAMPLE: The following has been paid on a claim:

Payments to physicians \$ 500.00 Payments to hospitals \$1,000.00 Temporary Total Disability \$2,000.00

A \$1,000.00 deductible has been recovered from the employer.

The amounts shown in box 19 should be as follows:

Medical \$1,500.00 Weekly Compensation \$2,000.00

Preparer Information

20. Preparer Name (Type or Print):

Enter the preparer's name.

E-Mail Address:

Enter the preparer's email address.

19. Telephone Number:

Enter the preparer's telephone number, including area code.

Toll Free Number:

Enter the preparer's toll free telephone number if one is available.

22. Date Mailed:

Enter the date (month, day, year) this form is sent (mail, fax, email) to the Board. When revising a previously filed form, write "REVISED" across the top of the form, put a line through the original Date Sent to WCB date and note the revision date.

NOTES

LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL / HEALTH CARE INFORMATION

STATE OF MAINE WORKERS'COMPENSATION BOARD

EMPLOYEE:	ADDRESS:
DATE OF INJURY:	SOCIAL SECURITY NUMBER: XXX-XX-
BRIEF DESCRIPTION OF BODY PART(S) INJURE	D:
EMPLOYER:	ADDRESS:
INSURER:	ADDRESS:
ATTORNEY:	ADDRESS:
osteopath, chiropractor, or other health ca any written information only which is or has regardless of date which relates to my _ only. This certificate of authorization remai any claim for compensation, any comp compensation. This certificate of authorization	nsurer, or their attorney to obtain from any hospital, physician are provider, after payment to the provider of a reasonable fees been prepared in connection with my examination or treatmen (i.e. body part and/or condition ins valid and must be honored for as long as I continue to make pensation payment scheme remains in effect, or I receivation does NOT permit the release of any information regarding transmitted disease treatment, testing, or counseling and does by any health care provider.
EMPLOYEE SIGNATURE	DATE

NOTICE TO THE EMPLOYEE

YOU HAVE 20 DAYS FROM RECEIPT OF THIS CERTIFICATE TO SIGN AND RETURN IT TO THE EMPLOYER OR INSURER. FAILURE TO SIGN AND RETURN THIS CERTIFICATE MAY RESULT IN A SUSPENSION OF ACTIVITY ON YOUR CLAIM FOR COMPENSATION, OR IF YOU ARE CURRENTLY RECEIVING COMPENSATION, YOUR PAYMENTS OF COMPENSATION MAY BE SUSPENDED UNTIL YOU SIGN AND RETURN THIS CERTIFICATE.

THIS IS THE AUTHORIZED FORM FOR THE RELEASE OF MEDICAL AND RELATED INFORMATION UNDER THE MAINE WORKERS' COMPENSATION ACT AND IS INTENDED TO SUPPLEMENT THE RIGHTS TO SECURE MEDICAL INFORMATION SET FORTH BY TITLE 39-A OF THE MAINE REVISED STATUTES ANNOTATED AND CHAPTER 12, SECTION 18 OF THE BOARD'S RULES AND REGULATIONS.

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.

WCB-220 (eff. 1/1/15)

LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL/HEALTH CARE INFORMATION, WCB-220

Filing Requirements

In the event that the employer/insurer contends that the medical records and information, preexisting and subsequent to the workplace injury, for which claim is being made are relevant for determination of compensability and disability, it may obtain from the employee and the employee is obliged to within a reasonable time to execute the Limited Certificate Authorizing Written Release Of Medical/Health Care Information, WCB-220.

The employer/insurer must complete all informational areas of this form (except for Employee Signature and Date) before asking the employee to sign, date and return the form to them. This release in not valid without the employee's signature (or the signature of a person who has power of attorney for the injured employee).

Distribution

The Limited Certificate Authorizing Written Release of Medical/Health Care Information is a three-part form that is to be distributed as follows:

Copy 1 to the Employee Copy 2 to the Insurer Copy 3 to the Employer

The Board does not receive a copy of this report.

INSTRUCTIONS FOR COMPLETING LIMITED CERTIFICATE AUTHORIZING WRITTEN RELEASE OF MEDICAL/HEALTH CARE INFORMATION, WCB-220

Emplo	yee:
•	Enter the injured employee's name (first name, middle initial, last name).
Addres	ss:
	Enter the employee's mailing address (street or P.O. Box, city, state and zip code).
Date o	f Injury:
	Enter the date of the employee's injury. This date should be the same as box 42 of the
	Employer's First Report of Occupational Injury or Disease, WCB-1.
Social	Security Number:
	Enter the employee's social security number

Enter a list of the body parts af the body, be sure to indicate wi	fected by the injury or illness. When specifying a part of hether it is left or right. When the injury involves fingers rough five to describe the body part. (One is the thumb or or little toe.)
	be identified. This release applies only to a re related to the specific body part(s) or condition(s)
Employer:	
Enter the employer name as it of Occupational Injury or Disease	was entered in box 10 of the Employer's First Report of e, WCB-1.
Address:	
	aployer receives mail. Also enter the employer's phone
Insurer:	
Enter the name of the employe	r's workers' compensation insurance company. If the up self-insured, indicate this and provide the name of the re is one.
Address:	or third-party administrator's mailing address.
Attorney (Legal Representative): If the employee is represented representative.	by a legal representative, enter the name of that legal
Address:Enter the legal representative's	mailing address.
physician, osteopath, chiropractor, or of a reasonable fee, any written information or treatment regardles part and/or condition) only. This certifor as long as I continue to make any oscheme remains in effect, or I receive permit the release of any information in	r, insurer, or their attorney to obtain from any hospital, other health care provider, after payment to the provider of on only which is or has been prepared in connection with as of date which relates to my (i.e. body ficate of authorization remains valid and must be honored claim for compensation, any compensation payment compensation. This certificate of authorization does NOT regarding psychological, substance abuse, sexually or counseling and does NOT authorize oral care provider.
Employee Signature	 Date

The injured employee, or a person who holds power of attorney for the employee, **must** sign the first line and enter the date of their signature on the second line.

NOTES

EMPLOYMENT STATUS REPORT

STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

PART I (COMPLETED BY EMPLOYER/INSURER)					
1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	(last 4 digits):	7. WCB FILE NUM	(BER:	
	XXX-XX-				
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:		9. FIRST NAME:		10. M.I.:
					l
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11 ADDRESS-NUMBER AND S	TREET-			
4. INSURER NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME F	HONE:
		l			
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIP	TION OF INJURY:		
18.					
	OTICE TO EMPLOY	/FR			
	onice to Emil Eot				
ANY EMPLOYER REQUESTING A QUARTERLY RE	PORT MUST PROVIDE THE	EMPLOYEE	WITH THIS FOR	MATIFAS	T 15 DAYS
PRIOR TO THE DATE ON WHICH THE REPORT IS					
		_			
19.					
NO.	OTICE TO EMPLOY	/EE			
COMPLETE BOXES 20 AND 21AND RETURN THIS RETURN THIS REPORT MAY AFFECT YOUR WOR				TO COMPL	ETE AND
RETORN THIS REPORT MAT AT LCCT TOOK WOR	KENS COMPENSATION INC	JEMINITI DE	ALITIS.		
THIS REPORT IS DUE:					
THIS REPORT COVERS THE PERIOD FROMTO					
PART II (COMPLETED BY THE EMPLOYEE)					
20.					
A. HAVE YOU BEEN EMPLOYED, CHANGED EMP	LOYMENT OR PERFORMED	ANY SERVI	CES FOR COMP	ENSATION	
DURING THE PERIOD STATED IN THE ABOVE SECTION?					
YES NO					
B. IF YES, COMPLETE THE FOLLOWING FOR EA	ACH EMPLOYER AND ATTA	CH VERIFIC	ATION OF INCOM	ME:	
EMPLOYER NAME: TELEPHONE:					
EMPLOYER NAME:	TELEPHON	E:			-
ADDRESS:					_
CITY:	STATE:	710-			
WIII.	OINIL.				-
NATURE OF THE EMPLOYMENT OR SERVICES					
EMPLOYED FROM:	то				
1		_			
ARE YOU STILL EMPLOYED? YES	NO L				
21. I HEREBY CERTIFY THAT THE INFORMATION CONTAINED IN THIS REPORT IS TRUTHFUL AND ACCURATE.					
The second of th	John Market III III IVE	511. 30 1110			
EMPLOYEE SIGNATURE			DATE		

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711. WCB-230 (eff. 1/1/13)

EMPLOYMENT STATUS REPORT, WCB-230

Reporting Requirements

Pursuant to Section 308(2), at the previous employer's request, any person receiving compensation under this Act who has not returned to that person's previous employment must submit quarterly employment status reports to that employer. The report is due 90 days after the date of injury, or after the filing of the report and every 90 days thereafter. Any employer requesting a quarterly report must provide the employee with the prescribed form at least 15 days prior to the date on which it is due.

Distribution

Pursuant to Rule 1.8, the Employment Status Report is a three-part form that is to be distributed as follows:

Copy 1	to the Employee
Copy 2	to the Insurer
Copy 3	to the Employer

The Board does not receive a copy of this report.

INSTRUCTIONS FOR COMPLETING EMPLOYMENT STATUS REPORT, WCB-230

Part I Completed By Employer/Insurer

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

Notice to Employer

18. This section notifies the employer when to send this form to the employee. Employer must complete the information in box 19 for the employee notice.

Notice to Employee

19. This section notifies the employee or his or her responsibilities.

This Report is Due: Employer must enter the d	late the repo	ort is due.
This Report Covers the Period From	to	: Employer must enter
the from and to dates covered by this report.		

Part II Completed By The Employee

- 20A. Have you been employed, changed employment or performed any services for compensation during the period stated in box 19?

 Check either Yes or No.
- 20B. If Yes is checked, complete this section with the name, address, and telephone number(s), nature of employment and dates of employment for each new employer(s). (Use reverse side of report, if necessary.) **Attach verification of income from each new employer.**
- 21. Sign and date this form to certify that the information is truthful and accurate.

NOTES

EMPLOYEE'S RETURN TO WORK REPORT

STATE OF MAINE WORKERS' COMPENSATION BOARD 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027

INCHIDED	PLETED BY EMPLOYER/INSURER)					
. INSURER	FILE NUMBER:	6. SOCIAL SECURITY NUM	/BER (last 4 digits):	7. WCB FILE NU	MBER:	
		XXX-XX-				
EMPLOYE	R NAME:	8. EMPLOYEE LAST NAME	È	9. FIRST NAME:		10. M.I.:
						l
. EMPLOYE	R MAILING ADDRESS AND PHONE NUMBER	ER: 11. ADDRESS-NUMBER A	ND STREET:			
INSURER I	NAME:	12. CITY:	13. STATE:	14. ZIP:	15. HOME P	PHONE:
			1			
INSURER	MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPT	TION OF INJURY:		
18.						
	NOT	ICE TO EMPLOYER	R/INSURER			
THE EMPI	OVERHALIDED QUALL CENT THE	ENDLOYEE'S BETURN TO U	NOBY BEDORT	O THE ENDLO	VEE WUEN 6	EII ING THE
	LOYER/INSURER SHALL SEND THE E NDUM OF PAYMENT PURSUANT TO		VORK REPORT	O THE EMPLO	TEE WHEN I	FILING THE
19.						
		NOTICE TO EMPL	OVEE			
		NOTICE TO EMPL	OTEE			
	ETURN TO WORK WITH A NEW EMPI	LOYER, COMPLETE BOXES	20 AND 21 AND			
THE BOAF	ETURN TO WORK WITH A NEW EMPI RD AND YOUR PREVIOUS EMPLOYE	LOYER, COMPLETE BOXES	20 AND 21 AND			
THE BOAF M.R.S.A. §	ETURN TO WORK WITH A NEW EMP RD AND YOUR PREVIOUS EMPLOYE (308(1).	LOYER, COMPLETE BOXES R AT THE ADDRESSES LIS	20 AND 21 AND TED ABOVE WIIT	THIN 7 DAYS PL	JRSUANT TO	39-A
THE BOAF M.R.S.A. §	ETURN TO WORK WITH A NEW EMPI RD AND YOUR PREVIOUS EMPLOYE	LOYER, COMPLETE BOXES R AT THE ADDRESSES LIS	20 AND 21 AND TED ABOVE WIIT	THIN 7 DAYS PL	JRSUANT TO	39-A
THE BOAF M.R.S.A. §	ETURN TO WORK WITH A NEW EMP RD AND YOUR PREVIOUS EMPLOYE (308(1). TO COMPLETE AND RETURN THIS R	LOYER, COMPLETE BOXES R AT THE ADDRESSES LIS	20 AND 21 AND TED ABOVE WIIT	THIN 7 DAYS PL	JRSUANT TO	39-A
THE BOAF M.R.S.A. § FAILURE 1	ETURN TO WORK WITH A NEW EMP RD AND YOUR PREVIOUS EMPLOYE (308(1).	LOYER, COMPLETE BOXES R AT THE ADDRESSES LIS	20 AND 21 AND TED ABOVE WIT R WORKERS' CO	THIN 7 DAYS PL	JRSUANT TO	39-A
THE BOAF M.R.S.A. § FAILURE 1 PART II (CO 20. COMP	ETURN TO WORK WITH A NEW EMPL RD AND YOUR PREVIOUS EMPLOYE (308(1)). TO COMPLETE AND RETURN THIS R OMPLETED BY THE EMPLOYEE)	LOYER, COMPLETE BOXES R AT THE ADDRESSES LIS EPORT MAY AFFECT YOUR ON (USE REVERSE SIDE IF	20 AND 21 AND TED ABOVE WITH R WORKERS' CO NECESSARY).	THIN 7 DAYS PU	IRSUANT TO	BENEFITS.
THE BOAF M.R.S.A. § FAILURE 1	ETURN TO WORK WITH A NEW EMPLOYE (308(1). TO COMPLETE AND RETURN THIS REPORTED BY THE EMPLOYEE)	LOYER, COMPLETE BOXES R AT THE ADDRESSES LIS EPORT MAY AFFECT YOUR ON (USE REVERSE SIDE IF	20 AND 21 AND TED ABOVE WITH R WORKERS' CO NECESSARY).	THIN 7 DAYS PU	IRSUANT TO	D 39-A BENEFITS.
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THE BOAF M.R.S.A. § FAILURE 1 PART II (CO 20. COMP	ETURN TO WORK WITH A NEW EMPLOYE (308(1). TO COMPLETE AND RETURN THIS RESERVED BY THE EMPLOYEE) LETE THE FOLLOWING INFORMATION NEW EMPLOYER NAME: ADDRESS:	LOYER, COMPLETE BOXES R AT THE ADDRESSES LIS EEPORT MAY AFFECT YOUR ON (USE REVERSE SIDE IF	220 AND 21 AND TED ABOVE WIIT R WORKERS' CO NECESSARY). _TELEPHONE:	THIN 7 DAYS PU	NDEMNITY E	D 39-A BENEFITS.
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THE BOAF M.R.S.A. § FAILURE : PART II (CO 20. COMP A. B. C.	ETURN TO WORK WITH A NEW EMPLOYE (308(1). TO COMPLETE AND RETURN THIS RETURN THE FOLLOWING INFORMATION NEW EMPLOYER NAME: ADDRESS: CITY: DATE OF HIRE: ATTACH VERIFICATION OF INCOME.	LOYER, COMPLETE BOXES R AT THE ADDRESSES LIS EPORT MAY AFFECT YOUR ON (USE REVERSE SIDE IF	220 AND 21 AND TED ABOVE WIIT R WORKERS' CO NECESSARY) TELEPHONE:ZII	MPENSATION I	NDEMNITY E	BENEFITS.
THE BOAFM.R.S.A. § FAILURE : PART II (CO 20. COMP) A. B. C.	ETURN TO WORK WITH A NEW EMPLOYE (308(1). TO COMPLETE AND RETURN THIS RETURN THE FOLLOWING INFORMATION NEW EMPLOYER NAME: ADDRESS: CITY: DATE OF HIRE: ATTACH VERIFICATION OF INCOME.	LOYER, COMPLETE BOXES R AT THE ADDRESSES LIS EPORT MAY AFFECT YOUR ON (USE REVERSE SIDE IF	220 AND 21 AND TED ABOVE WIIT R WORKERS' CO NECESSARY) TELEPHONE:ZII	MPENSATION I	NDEMNITY E	BENEFITS.

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711. WCB-231 (eff. 1/1/13)

DATE

EMPLOYEE SIGNATURE

EMPLOYEE'S RETURN TO WORK REPORT, WCB-231

Reporting Requirements

Pursuant to Section 308(1), any person receiving compensation under this Act who returns to employment or engages in new employment after that person's injury shall file a written report of that employment with the Board and that person's previous employer within 7 days of that person's return to work. This report must include the identity of the employee, the employee's employer and the amount of weekly wages or earnings received or to be received by the employee.

Per Rule 8.17, the employer/insurer shall send the Employee's Return to Work Report to the employee when filing the Memorandum of Payment, WCB-3, pursuant to Section 205(7).

Distribution

The Employee's Return to Work Report is a four-part form that is to be distributed as follows:

Copy 1 to the Board via e-mail, via fax, or via standard mail at:

Workers' Compensation Board 27 State House Station Augusta, Maine 04333-0027

Copy 2 to the Employee Copy 3 to the Insurer Copy 4 to the Employer

INSTRUCTIONS FOR COMPLETING EMPLOYEE'S RETURN TO WORK REPORT, WCB-231

Part I Completed By Employer/Insurer

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address and Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address – Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of the employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of the employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone Number:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

Notice to Employer/Insurer

18. This section notifies the employer/insurer when to send this form to the employee.

Notice to Employee

19. This section notifies the employee or his or her responsibilities.

Part II Completed By The Employee

- 20. Complete this section, supplying the following information:
 - A. Name, address, and telephone number(s) of each new employer.
 - B. Date(s) of hire.
 - C. Attach verification of income or list anticipated income with each new employer.
 - D. Use this space to provide any comments.
- 21. Sign and date this form to certify that the information is truthful and accurate.

NOTES

EMPLOYEE'S RETURN TO WORK REPORT

STATE OF MAINE WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

PART 1 (COMPLETED BY EMPLOYER/INSURER)					
1. INSURER FILE NUMBER:	6. SOCIAL SECURITY NUMBER	2	7. WCB FILE N	UMBER:	
	XXX-XX-				
2. EMPLOYER NAME:	8. EMPLOYEE LAST NAME:	9. FIRST NAME:		10. M.I.:	
3. EMPLOYER MAILING ADDRESS AND PHONE NUMBER:	11. ADDRESS-NUMBER AND S	TREET:			
4. INSURER NAME:	12. CITY:	43 STATE	14. ZIP:	15. HOME P	HONE:
A. INDURER INVIE.	12.011.	IS. OTATE.	14. ZF.	IS. HOWE P	HONE.
		1	1		
5. INSURER MAILING ADDRESS:	16. DATE OF INJURY:	17. DESCRIPT	ON OF INJURY:		
40					
18.	TO EMPLOYED!	MELIDED			
NOTIC	E TO EMPLOYER/I	NSURER			
THIS REPORT IS SENT TO THE EMPLOYEE WITH	THE 21-DAY CERTIFICATE	OF DISCONT	INI IANCE OR RE	EDUCTION	ne l
COMPENSATION OR THE PETITION FOR REVIEW			INGRITOR OIL IN	DOCTION	J.
19.					
Į N	OTICE TO EMPLOY	/EE			
VALID WEEK! V DENEEDS WILL BE DESCRICES OF	DISCONTINUES FASTOR	EV TO THE	MOUNT SHOW	LONZUE	
YOUR WEEKLY BENEFITS WILL BE REDUCED OF CERTIFICATE OF DISCONTINUANCE OR REDUCT					OURED
TO PROVIDE DOCUMENTATION TO THE INSUREI					
PETITION FOR REVIEW IS PENDING BEFORE TH					
BOX 20 BELOW. IF YOU FAIL TO PROVIDE DOCU					
DISCONTINANCE OR REDUCTION OR PETITION I	FOR REVIEW SHALL REMAI	N IN EFFECT	AND YOUR BEN	IEFITS WILL	. NOT BE
ADJUSTED.					
PART 2 (COMPLETED BY THE EMPLOYEE)					
20. COMPLETE THE FOLLOWING INFOR	MATION				
A INCOME FROM NEW EMPLOYMENT	/				
A. INCOME FROM NEW EMPLOYMENT	(attach verification):				
PAY PERIOD ENDING DATE	AMOU	NT			
TATTERIOD ENDING DATE	Amou				
PAY PERIOD ENDING DATE	AMOU	NT			
		_			
PAY PERIOD ENDING DATE	AMOU	NT			
PAY PERIOD ENDING DATE	AMOU	NT			
PAT PERIOD ENDING DATE	AMOU				
B. COMMENTS:					
21. I HEREBY CERTIFY THAT THE INFORMATION	CONTAINED IN THIS REPO	RT IS TRUTHE	FUL AND ACCUR	RATE.	
EMPLOYEE SIGNATURE			DATE		
EMPLOTEE GIGHATURE					

THE STATE OF MAINE DOES NOT DISCRIMINATE ON THE BASIS OF DISABILITY IN ADMISSION TO, ACCESS TO, OR OPERATION OF ITS PROGRAMS, SERVICES, OR ACTIVITIES. THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT. FOR FURTHER ASSISTANCE, CONTACT THE MAINE WORKERS' COMPENSATION BOARD, ADA COORDINATOR, TELEPHONE: 1-888-801-9087 OR TTY Maine Relay 711.

WCB-2114 (eff. 1/1/13)

EMPLOYEE'S RETURN TO WORK REPORT, WCB-231A

Reporting Requirements

Reduction or discontinuance pursuant to §205(9)(B)(1): Pursuant to Rule 8.15, the employer/insurer must include form WCB-231A (Employee's Return to Work Report) with the 21-day Certificate of Discontinuance or Reduction. Within 14 calendar days after the expiration of the 21-day period, or within 14 days after receipt of documentation from the employee if the documentation is received after the expiration of the 21-day period, the employer/insurer shall file with the Board the documentation it has received along with an amended form WCB-8 which shall also include any necessary adjustments based on the documentation received by the employer/insurer.

Reduction or discontinuance pursuant to § 205(9)(B)(2): Pursuant to Rule 8.15, the employer/insurer shall send to the employee form WCB-231A (Employee's Return to Work Report) in addition to the Petition for Review. The employer/insurer shall file the actual documented earnings and form WCB-4 showing the adjustment that was made with the Board at the same time it files the Petition for Review. Thereafter, the employer/insurer shall, within 30 days after receipt of the actual documented earnings, file with the Board the actual documentation it has received along with form WCB-4.

INSTRUCTIONS FOR COMPLETING EMPLOYEE'S RETURN TO WORK REPORT, WCB-231A

Part I Completed By The Employer/Insurer

1. Insurer File Number:

Enter the claim administrator claim number as it was entered in box 21 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

2. Employer Name:

Enter the employer name as it was entered in box 10 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

3. Employer Mailing Address or Phone Number:

Enter the employer mailing address and phone number as it was entered in boxes 11-15 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

4. Insurer Name:

Enter the legal name of the insurance company, self-insured or guarantee fund assuming the employer's financial responsibility for this claim as it was entered in box 19 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

5. Insurer Mailing Address:

Enter the claim administrator mailing address as it was entered in boxes 22-25 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

6. Social Security Number:

Enter the employee's ID# as it was entered in box 31 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

7. WCB File Number:

Enter the jurisdiction claim number assigned by the Board to identify this claim.

8. Employee Last Name:

Enter the employee's last name as it was entered in box 27 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

9. First Name:

Enter the employee's first name as it was entered in box 28 of the Employer's First Report of Occupational Injury of Disease, WCB-1.

10. M.I.:

Enter the employee's middle initial as it was entered in box 29 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

11. Address –Number and Street:

Enter the number and street of the employee's mailing address as it was entered in box 33 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

12. City:

Enter the city of employee's mailing address as it was entered in box 34 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

13. State:

Enter the state of employee's mailing address as it was entered in box 35 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

14. Zip:

Enter the zip code of the employee's mailing address as it was entered in box 36 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

15. Home Phone:

Enter the employee's home telephone number as it was entered in box 30 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

16. Date of Injury:

Enter the date of injury or illness as it was entered in box 42 of the Employer's First Report of Occupational Injury or Disease, WCB-1.

17. Description of Injury:

Enter a brief description of the injury or illness.

Notice to Employer/Insurer

18. This section notifies the employer/insurer when to send this form to the employee.

Notice to Employee

19. This section notifies the employee or his or her responsibilities.

Part II Completed By The Employee

- 20. Complete this section, supplying the following information:
 - A. Pay period ending date and amount of gross wages earned.
 - B. Use this space to provide any comments.
- 21. Sign and date this form to certify that the information is truthful and accurate.

NOTES

APPENDIX A: CALCULATION OF BENEFITS¹

INJURIES ON OR AFTER 1-1-93

The following method of calculating total incapacity benefits is acceptable for the purpose of Board audits:

Total Incapacity (Section 212)

Payments for a fraction of a week shall be figured in sevenths (1/7). This calculation includes Saturday and Sunday.

Example: Assume Hearing Officer orders employee to be paid for 16 days.

Weekly Compensation Rate x 2 2/7 = Weekly Compensation Rate x 16/7 = Amount Due

Partial Incapacity (Section 213)

Partial benefits are calculated at a rate of 80% of the difference between the employee's after-tax average weekly wage before the injury and the after-tax average weekly wage after the injury.

To calculate partial benefits:

- (1) Determine the weekly compensation rate for the employee's pre-injury average weekly wage.
- (2) Determine the weekly compensation rate for the employee's post-injury gross weekly wages.
- (3) Subtract the post-injury rate from the pre-injury rate. The difference between the post-injury rate and the pre-injury rate is the partial benefit amount due.

Example: Assume January 1996 date of injury, pre-injury average weekly wage of \$400, and filing status of married/joint with two dependents. Employee returns to work part-time, earning \$200 per week.

Wage Rate \$400 \$266.66 \$200 \$133.33 \$133.33 Partial Benefit Amount Due

¹ If fringe benefits are involved, they will be included pursuant to Section 102(4)(H).

APPENDIX B: AWW CALCULATION

Average weekly wages must be calculated in accordance with Section 102(4), of the Maine Workers' Compensation Act of 1992. Furthermore, the applicability of subsections A, B, C and D must be considered in the order that those subsections appear.

The following pages provide examples of typical WCB-2, Wage Statements. Each example contains an "AWW calculation explanation" at the bottom of the page. These "AWW calculation explanations" are designed to offer general guidance for the application of Section 102(4). They are for illustrative purposes only, and do not represent official Board policy.

WAGE STATEMENT STATE OF MAINE WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER: EMPLOYER NAME:			6. SOCIAL SECURITY NUMBER				7. \	WCB FILE NU	JMBER:		
2. EMP	LOYER NAME:			8. EMPLOYEE LA	AST NAM	ΛE:		9. FIR	RST NAME:		10. M.I.:
		Store							Bess	S	
3. EMP	LOYER MAILING A	ADDRESS AND PHONE	NUMBER	: 11. ADDRESS-NU	JMBER	AND ST	REET:				
4. INSUI	RER NAME:			12. CITY:			13. STATE	: 14. 2	ZIP:	15. HOM	E PHONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJ		1	7. DESCRIP	TION OI	F INJURY:	I.	
				5/10/	/11						
10.00	NEO EMBLOVEE M	10014			40.04	050 5145	N 0.VEE DE)="\/F	TO IN OF		
FO	ES EMPLOYEE W	LOYER?		YES	BE	ENEFITS	THAT MAY	STOP W	VHILE ON		YES
ST		YER SHALL SUBMIT A V EACH ADDITIONAL EMF		NO 🗌	V	ORKER	S; COMPENS	SATION	·?.		NO 🗌
20 WK	WEEK ENDING	GROSS EARNINGS	WK					WK			
1	5/22/10	400.00	19	9/25/10			350.00	37	1/29/11		225.00
2	5/29/10	425.00	20	10/2/10			250.00	38	2/5/11		225.00
3	6/5/10	425.00	21	10/9/10			325.00	39	2/12/11		350.00
4	6/12/10	425.00	22	10/16/10			200.00	40	2/19/11		275.00
5	6/19/10	450.00	23	10/23/10			250.00	41	2/26/11		275.00
6	6/26/10	425.00	24	10/30/10			300.00	42	3/5/11		250.00
7	7/3/10	500.00	25	11/6/10			250.00	43	3/12/11		225.00
8	7/10/10	475.00	26	11/13/10			300.00	44	3/19/11		325.00
9	7/17/10	450.00	27	11/20/10			325.00	45	3/26/11		350.00
10	7/24/10	450.00	28	11/27/10			500.00	46	4/2/11		400.00
11	7/31/10	450.00	29	12/4/10			450.00	47	4/9/11		400.00
12	8/7/10	490.00	30	12/11/10			425.00	48	4/16/11		350.00
13	8/14/10	Includes advance vacation pay 800.00	31	12/18/10			455.00	49	4/23/11		325.00
14	8/21/10	0.00	32	12/25/10			650.00	50	4/30/11		375.00
15	8/28/10	425.00	33	1/1/11			400.00	51	5/7/11		350.00
16	9/4/10	425.00	34	1/8/11			300.00	52	5/14/11		400.00
17	9/11/10	350.00	35	1/15/11		,	250.00	21. TO	TAL RNINGS	s 19	9,020.00
18	9/18/10	325.00	36	1/22/11			250.00		OSS AVERAGE		

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. Vacation pay for the week ending 8/21/10 appears to have been paid during the week ending 8/14/10 (see documentation above). Therefore, the Total Earnings should be divided by 52 weeks (§102(4)(B)).

WAGE STATEMENT STATE OF MAINE WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER: EMPLOYER NAME:				6. SOCIAL SECURITY NUMBER				7. WCB FILE NUMBER:			
2. EMPI		oloyed logger		8. EMPLOYEE LA	ST NAME	E:		9. FIR	ST NAME: Chuc	ŀ	10. M.I.:
2 EMDI	-	DDRESS AND PHONE	NI IMPED:	11. ADDRESS-NU	IMPED AI	ND STD	сст.		Cituc	·K	
3. EIVIF	OTER MAILING A	ADDRESS AND PHONE	NUMBER.	11. ADDRESS-NO	JIVIDEK AI	IND STR	EE1.				
4. INSUF	RER NAME:			12. CITY:			13. STATE:	: 14. Z	IP:	15. HOME	PHONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJU		17	. DESCRIP	TION OF	FINJURY:		
				1		<u> </u>					
FO IF `				YES NO	BEN	NEFITS T	LOYEE REC THAT MAY S ; COMPENS	STOP W	HILE ON		YES NO
20. WK	WEEK ENDING	GROSS EARNINGS	WK					WK			
1	1/8/10	800.00	19	5/14/10		13	350.00	37	9/17/10)	1225.00
2	1/15/10	825.00	20	5/21/10		ç	950.00	38	9/24/10)	1225.00
3	1/22/10	725.00	21	5/28/10		13	325.00	39	10/1/10)	1350.00
4	1/29/10	925.00	22	6/4/10		12	200.00	40	10/8/10)	725.00
5	2/5/10	950.00		6/11/10		12	250.00	41	10/15/1	10	275.00
6	2/12/10	925.00		6/18/10		13	300.00	42	10/22/1	10	1450.00
7	2/19/10	1500.00		6/25/10		12	250.00	43	10/29/1	10	1450.00
8	2/26/10	1475.00	26	7/2/10		13	300.00	44	11/5/10)	1450.00
9	3/5/10	0.00		7/9/10		13	325.00	45	11/12/1	10	890.00
10	3/12/10	0.00		7/16/10		5	500.00	46	11/19/1	10	800.00
11	3/19/10	0.00		7/23/10		5	550.00	47	11/26/1	10	780.00
12	3/26/10	0.00		7/30/10		8	325.00	48	12/3/10)	1425.00
13	4/2/10	0.00		8/6/10		7	755.00	49	12/10/1	10	1425.00
14	4/9/10	0.00		8/13/10		6	650.00	50	12/17/1	10	1350.00
15	4/16/10	.00		8/20/10			100.00	51	12/24/1	10	650.00
16	4/23/10	0.00		8/27/10		7	700.00	52	12/31/1	10	700.00
17	4/30/10	0.00	35	9/3/10		12	250.00	21. TOT EAF	AL	s 43,	750.00
18	5/7/10	325.00	36	9/10/10		12	250.00		OSS AVERAGE		1.35

AWW calculation explanation: Logging is seasonal employment (§102(4)(C)). Therefore, all wages, earnings or salary for the prior calendar year must be divided by 52 weeks.

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	RER FILE NUMBE	R:		6. SOCIAL SECU	RITY NU	JMBER		7. \	WCB FILE NU	JMBER:	
2. EMP	LOYER NAME:	Store		8. EMPLOYEE LA	AST NAM	ME:		9. FIF	RST NAME:)	10. M.I.:
3. EMP	LOYER MAILING A	ADDRESS AND PHONE	NUMBER:	11. ADDRESS-NI	JMBER	AND STR	EET:				
4. INSUI	RER NAME:			12. CITY:			13. STATE	14. 2	ZIP:	15. HOM	ME PHONE:
5. INSU	RER MAILING AD	DRESS:		16. DATE OF INJ 5/12/		17	. DESCRIP	L TION O	F INJURY:		
FO IF `				YES NO	BE	ENEFITS T	LOYEE REC THAT MAY S ; COMPENS	STOP V	VHILE ON		YES NO
WK 1	WEEK ENDING	GROSS EARNINGS	WK 19					WK 37			
2	5/22/10	200.00	20	9/25/10		1	50.00	38	1/29/11		325.00
3	5/29/10	225.00	21	10/2/10		2	200.00	39	2/5/11		400.00
4	6/5/10	400.00	22	10/9/10		4	25.00	40	2/15/11	<u> </u>	225.00
-	6/12/10	325.00		10/16/10		3	375.00		2/19/11	1	250.00
5	6/19/10	275.00	23	10/23/10		1	75.00	41	2/26/11	1	330.00
6	6/26/10	280.00	24	10/30/10		1	25.00	42	3/5/11		320.00
7	7/3/10	400.00	25	11/6/10		1	55.00	43	3/12/11		275.00
8	7/10/10	475.00	26	11/13/10		1	45.00	44	3/19/11		250.00
9	7/17/10	425.00	27	11/20/10		2	275.00	45	3/26/11	1	200.00
10	7/24/10	425.00	28	11/27/10		2	25.00	46	4/2/11		200.00
11	7/31/10	340.00	29	12/4/10		2	250.00	47	4/9/11		450.00
12	8/7/10	350.00	30	12/11/10		2	275.00	48	4/16/11		400.00
13	8/14/10	230.00	31	12/18/10		(3)	300.00	49	4/23/11	1	325.00
14	8/21/10	320.00	32	12/25/10		(3)	350.00	50	4/30/11		350.00
15	8/28/10	425.00	33	1/1/11			60.00	51	5/7/11		180.00
16	9/4/10	400.00	34	1/8/11			40.00	52	5/14/11		220.00
17	9/11/10	350.00	35	1/15/11		1	30.00		RNINGS		4,895.00
18	9/18/10	375.00	36	1/22/11		1	20.00		OSS AVERAGE		87.75

AWW calculation explanation: This employee's biweekly earnings generally varied, so §102(4)(A) cannot be used. The week ending 5/14/11 includes the date of injury and reduces the AWW, so it should be excluded. The remainder (\$14,675.00) should then be divided by 51 weeks (\$102(4)(B)).

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER: EMPLOYER NAME:				6. SOCIAL SECURITY NUMBER				7. WCB FILE NUMBER:			
O EMPI	OVED NAME:			0. EMPLOYEE LA	OT NAM	45.		I O FID	ST NAME:		40 MI
2. EMPI		Store		8. EMPLOYEE LA	STNAN	ИE:		9. FIR	David	d	10. M.I.:
3. EMPI	OYER MAILING A	ADDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER .	AND ST	REET:	ı			
4. INSUF	RER NAME:			12. CITY:			13. STATE:	14. Z	IP:	15. HOME F	HONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJU 6/15/		1	17. DESCRIP	TION OF	FINJURY:		
FO IF ' ST				YES NO	BE	ENEFITS	IPLOYEE REC S THAT MAY : RS; COMPENS	STOP W	/HILE ON		YES NO
20. WK	WEEK ENDING	GROSS EARNINGS	WK					WK			
1			19					37			
2			20					38			
3			21					39			
4			22					40			
5			23					41			
6			24					42			
7			25					43			
8			26					44			
9			27					45			
10			28					46			
11			29					47			
12			30					48			
13			31					49	5/28/11		50.00
14			32					50	6/4/11		400.00
15			33					51	6/11/11		200.00
16			34					52	6/18/11		150.00
17			35					21. TOT	I TAL RNINGS	\$ 800	.00
18			36					22. GR	OSS AVERAGE		known

AWW calculation explanation: There are not enough weeks to apply §102(4)(A), and §102(4)(C) cannot be used because this is not seasonal employment. Section 102(4)(B) may not be reasonable or fair in this case, therefore, comparable employees' wages should be obtained and reviewed along with this employee's previous wages, earnings or salary in order to arrive at an AWW that reasonably represents the employee's weekly earning capacity (§102(4)(D)).

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	INSURER FILE NUMBER: EMPLOYER NAME:			6. SOCIAL SECURITY NUMBER				7. V	WCB FILE NU	JMBER:	
2. EMP		actory		8. EMPLOYEE LA	AST NAM	ME:		9. FIR	RST NAME:	e	10. M.I.:
3. EMP	LOYER MAILING A	ADDRESS AND PHONE	NUMBER	R: 11. ADDRESS-NU	JMBER	AND STR	REET:	•			
4. INSUI	RER NAME:			12. CITY:			13. STATE	: 14. Z	ZIP:	15. HOME	PHONE:
5. INSU	RER MAILING AD	DRESS:		16. DATE OF INJ		17	T. DESCRIP	L TION OF	F INJURY:		
FO IF ST				YES NO	В	ENEFITS	PLOYEE REG THAT MAY S; COMPEN:	STOP W	VHILE ON		YES NO
20. WK	WEEK ENDING	GROSS EARNINGS	WK					WK			
1	8/7/10	420.00	19	12/11/10		4	468.00	37	4/16/11	1	650.00
2	8/14/10	400.00	20	12/18/10		4	492.00	38	4/23/11	1	650.00
3	8/21/10	352.00	21	12/25/10			500.00	39	4/30/11	1	425.00
4	8/28/10	468.00	22	1/1/11		4	488.00	40	5/7/11		455.00
5	9/4/10	500.00	23	1/8/11			500.00	41	5/14/11	1	465.00
6	9/11/10	325.00	24	1/15/11		4	472.00	42	5/21/11	1	410.00
7	9/18/10	250.00	25	1/22/11		4	468.00	43	5/28/11	1	465.00
8	9/25/10	600.00	26	1/29/11		;	300.00	44	6/4/11		400.00
9	10/2/10	425.00	27	2/5/11		;	350.00	45	6/11/11	1	500.00
10	10/9/10	390.00	28	2/12/11		,	375.00	46	6/18/11	1	352.00
11	10/16/10	350.00	29	2/19/11			590.00	47	6/25/11	1	468.00
12	10/23/10	425.00	30	2/26/11			425.00	48	7/2/11		500.00
13	10/30/10	400.00	31	3/5/11			400.00	49	7/9/11		325.00
14	11/06/10	600.00	32	3/12/11		;	350.00	50	7/16/11	I	250.00
15	11/13/10	525.00	33	3/19/11			400.00	51	7/23/11		425.00
16	11/20/10	500.00	34	3/26/11			425.00	52	7/30/11		100.00
17	11/27/10	550.00	35	4/2/11		;	325.00		RNINGS		,848.00
18	12/4/10	600.00	36	4/9/11			600 00		OSS AVERAGE		6 04

| 12/4/10 | 600.00 | 4/9/11 | 600.00 | WEEKLY WAGE \$ 446.04 |

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. The week ending 7/30/11 includes the date of injury and reduces the AWW, so it should be excluded. The remainder (\$22,748.00) should then be divided by 51 weeks (§102(4)(B)).

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER: EMPLOYER NAME:				6. SOCIAL SECU	RITY NUI	MBER		7. WCB FILE NUMBER:			
2. EMPI		Office		8. EMPLOYEE LA	ST NAMI	E:		9. FIR	ST NAME: Barba	ıra	10. M.I.:
3. EMPI	OYER MAILING A	ADDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER A	AND STRI	EET:				
4. INSUF	RER NAME:			12. CITY:			13. STATE	: 14. Z	IP:	15. HOME F	PHONE:
5. INSU	RER MAILING AD	DRESS:		16. DATE OF INJU 7/26/		17	. DESCRIP	TION OF	FINJURY:	I	
FO IF `				YES			STOP W	HILE ON		YES NO	
WK 1	WEEK ENDING	GROSS EARNINGS	WK 19					WK 37	4/16/11	I	450.00
2			20	12/18/10		2	250.00	38	4/23/11		450.00
3				12/25/10		4	150.00	39	4/30/11	I	450.00
4				1/1/11		4	150.00	40	5/7/11		450.00
5				1/8/11		4	150.00	41	5/14/11	I	450.00
6				1/15/11		4	150.00	42	5/21/11	I	450.00
7			25	1/22/11		4	150.00	43	5/28/11	I	450.00
8				1/29/11		4	150.00	44	6/4/11		450.00
9				2/5/11		4	150.00	45	6/11/11		450.00
10				2/12/11		4	50.00	46	6/18/11	ļ	450.00
11				2/19/11		4	150.00	47	6/25/11		450.00
12				2/26/11		4	150.00	48	7/2/11		450.00
13				3/5/11		4	150.00	49	7/9/11		450.00
14				3/12/11		4	150.00	50	7/16/11	1	450.00
15				3/19/11		4	150.00	51	7/23/11	I	450.00
16			34	3/26/11		4	150.00	52	7/30/11	1	300.00
17				4/2/11		4	150.00		NINGS		500.00
18			36				150.00		DSS AVERAGE		0.00

AWW calculation explanation: It appears that this employee did not work at least 200 full workdays during the preceding year, so §102(4)(A) cannot be used. The week ending 12/18/10 includes the week of hire, and the week ending 7/30/11 includes the date of injury. Both of the aforementioned weeks reduce the AWW, and should therefore be excluded. The remainder (\$13,950.00) should then be divided by 31 weeks (§102(4)(B)).

WAGE STATEMENT STATE OF MAINE KERS' COMPENSATION R

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	RER FILE NUMBE	R:		6. SOCIAL SECU	RITY NU	JMBER		7. \	VCB FILE NU	JMBER:	
2. EMP	LOYER NAME:	actory		8. EMPLOYEE LA	AST NAM	ИЕ:		9. FIR	Breno	da	10. M.I.:
3. EMP	LOYER MAILING A	ADDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER	AND STR	EET:	•			
4. INSUI	RER NAME:			12. CITY:			13. STATE:	14. 2	ZIP:	15. HON	ME PHONE:
5. INSU	RER MAILING AD	DRESS:		16. DATE OF INJ		17	Z. DESCRIP	TION OI	F INJURY:		
FO IF				YES NO	BE	ENEFITS '	LOYEE REC THAT MAY S	STOP W	/HILE ON		YES NO
WK 1	WEEK ENDING	GROSS EARNINGS	WK 19	10/11/10			169.00	WK 37	4/16/11	1	650.00
2	8/7/10	420.00	20	12/11/10			168.00	38			650.00
3	8/14/10	400.00	21	12/18/10 12/25/10			192.00 500.00	39	4/23/11		650.00 425.00
4	8/28/10	468.00	22	1/1/11			0.00	40	5/7/11	'	455.00
5	9/4/10	500.00	23	1/8/11		5	500.00	41	5/14/11	1	465.00
6	9/11/10	325.00	24	1/15/11		4	172.00	42	5/21/11	1	410.00
7	9/18/10	250.00	25	1/22/11		4	468.00	43	5/28/11	1	465.00
8	9/25/10	600.00	26	1/29/11		3	300.00	44	6/4/11		400.00
9	10/2/10	425.00	27	2/5/11		3	350.00	45	6/11/11	1	500.00
10	10/9/10	390.00	28	2/12/11		3	375.00	46	6/18/11	1	352.00
11	10/16/10	350.00	29	2/19/11			0.00	47	6/25/11	1	468.00
12	10/23/10	425.00	30	2/26/11		4	125.00	48	7/2/11		500.00
13	10/30/10	400.00	31	3/5/11		4	400.00	49	7/9/11		325.00
14	11/06/10	600.00	32	3/12/11		3	350.00	50	7/16/11	1	0.00
15	11/13/10	525.00	33	3/19/11		4	400.00	51	7/23/11	1	425.00
16	11/20/10	500.00	34	3/26/11			125.00	52	7/30/11	1	600.00
17	11/27/10	550.00	35	4/2/11		3	325.00		RNINGS		1,668.00
18	12/4/10	600.00	36	4/9/11		6	500.00		OSS AVERAGE		151.42

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. There were no earnings during the weeks ending 8/21/10, 1/1/11, 2/19/11 and 7/16/11, so those weeks should be excluded, and the Total Earnings should be divided by 48 weeks (§102(4)(B)).

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSUF	. INSURER FILE NUMBER: 2. EMPLOYER NAME:			6. SOCIAL SECURITY NUMBER				7. V	VCB FILE NU	JMBER:	
2 FMPI	OYER NAME:			8. EMPLOYEE LA	ST NAM	IE.		9 FIR	ST NAME:		10. M.I.:
Z. LIVII L		mer Camp		o. Livii Lottee Ex	101 147 1171	· L ·		5.111	Carl		10. 141.1
3. EMPL	OYER MAILING A	ADDRESS AND PHONE	NUMBER:	11. ADDRESS-NU	JMBER A	AND STR	REET:				
							T	1		I	
4. INSUF	RER NAME:			12. CITY:			13. STATE:	14. 2	IP:	15. HOME F	PHONE:
5. INSU	RER MAILING AD	DRESS:		16. DATE OF INJU 8/16/		17	7. DESCRIPT	ION OI	F INJURY:	l	
FO IF \ ST/				YES NO	BE	NEFITS	PLOYEE RECI THAT MAY S S; COMPENS	TOP V	HILE ON		YES NO
20. WK	WEEK ENDING	GROSS EARNINGS	WK					WK			
1			19					37			
2			20					38			
3			21					39			
4			22					40			
5			23					41			
6			24					42			
7			25					43	6/18/11		400.00
8			26					44	6/25/11		400.00
9			27					45	7/2/11		400.00
10			28					46	7/9/11		400.00
11			29					47	7/16/11		400.00
12			30					48	7/23/11	I	400.00
13			31					49	7/30/11		400.00
14			32					50	8/6/11		400.00
15			33					51	8/13/11		400.00
16			34					52	8/20/11		400.00
17			35					21. TO	TAL RNINGS	s 4.0	00.00
18 36			36							=	
								22. GROSS AVERAGE WEEKLY WAGE \$ UNKNOWN			known

AWW calculation explanation: Summer camps are seasonal employment (§102(4)(C)). Therefore, all wages, earnings or salary for the prior calendar year must be obtained and then be divided by 52 weeks. (The wages listed above are for the current calendar year.)

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	RER FILE NUMBE		6. SOCIAL SECURITY NUMBER				7. V	VCB FILE NU	IMBER:		
2 FMPI	LOYER NAME:			8. EMPLOYEE LA	ST NAME:			9 FIR	ST NAME:		10. M.I.:
		School		0. 2 20 . 22 2				0	Barne	ev	101111111
2 EMDI		DDRESS AND PHONE	WI IMPED:	11. ADDRESS-NU	IMPED AND	O CTREE	т.				
3. EIVIPI	LOTER MAILING A	ADDRESS AND PHONE	NUIVIDER:	II. ADDRESS-NO	JIVIDER AINL	DSIKEE	1:				
4. INSUF	RER NAME:			12. CITY:		13	. STATE:	14. Z	IP:	15. HOM	IE PHONE:
								1			
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJU 9/26/	-	17. D	ESCRIP	ION OF	INJURY:		
)/20/	11						
	ES EMPLOYEE W			YES	19. DOES						YES
IF `		YER SHALL SUBMIT A V		NO \square		FITS THA RKERS; C					NO \square
20.		EACH ADDITIONAL EMP	PLOYER.								
WK 1	WEEK ENDING	GROSS EARNINGS	WK 19					WK 37			
	10/9/10	750.00		2/12/11		75	0.00		6/18/11		750.00
2	10/16/10	750.00		2/19/11		75	0.00	38	6/25/11		0.00
3	10/23/10	750.00	21	2/26/11		75	0.00	39	7/2/11		0.00
4	10/30/10	750.00	22	3/5/11		75	0.00	40	7/9/11		0.00
5	11/6/10	750.00	23	3/12/11		75	0.00	41	7/16/11		0.00
6	11/13/10	750.00	24	3/19/11		75	0.00	42	7/23/11		0.00
7	11/20/10	750.00		3/26/11		75	0.00	43	7/30/11		0.00
8	11/27/10	750.00	26	4/2/11		75	0.00	44	8/6/11		0.00
9	12/4/10	750.00		4/9/11		75	0.00	45	8/13/11		0.00
10	12/11/10	750.00		4/16/11		75	0.00	46	8/20/11		0.00
11	12/18/10	750.00		4/23/11		75	0.00	47	8/27/11		0.00
12	12/25/10	750.00		4/30/11		75	0.00	48	9/3/11		800.00
13	1/1/11	750.00		5/7/11		75	0.00	49	9/10/11		800.00
14	1/8/11	750.00		5/14/11		75	0.00	50	9/17/11		800.00
15	1/15/11	750.00		5/21/11		75	0.00	51	9/24/11		800.00
16	1/22/11	750.00	34	5/28/11		75	0.00	52	10/1/11		800.00
17	1/29/11	750.00		6/4/11		75	0.00		NINGS		1,750.00
18	0/5/11	750.00	36	C/4.4./4.4		75	0.00	22. GRC	SS AVERAGE		7EE 0E

AWW calculation explanation: Most teachers and other school personnel do not work at least 200 full workdays during a calendar year. Therefore, $\S102(4)(A)$ cannot be used in those situations. Based on the actual circumstances of the employment, $\S102(4)(B)$ might produce a fair and reasonable AWW (Total Earnings divided by 42 weeks = \$755.95.) If it does not, comparable employees' wages must be obtained and reviewed along with this employee's previous wages, earnings or salary in order to arrive at a fair and reasonable AWW ($\S102(4)(D)$). [$\S102(4)(C)$ cannot be used because schools are not seasonal employers.]

WAGE STATEMENT STATE OF MAINE ZERS! COMPENSATION R

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

INSURER FILE NUMBER: EMPLOYER NAME:			6. SOCIAL SECU	IRITY NI	UMBER		7. WCB FILE NUMBER:				
2. EMPI		Office		8. EMPLOYEE LA	AST NAI	ME:		9. FIR	ST NAME:	e	10. M.I.:
3. EMPI		ADDRESS AND PHONE	NUMBER	R: 11. ADDRESS-N	UMBER	AND STREET	Γ:				
4. INSUI	RER NAME:			12. CITY:		13.	STATE	: 14. Z	IP:	15. HOME	PHONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJ		17. DI	ESCRIP [*]	TION OF	FINJURY:		
FO IF `		'LOYER? YER SHALL SUBMIT A V		YES NO	ВІ	OES EMPLOY ENEFITS THA VORKERS; CO	T MAY	STOP W	HILE ON		YES NO
20.		EACH ADDITIONAL EMI									
WK 1	10/16/10	GROSS EARNINGS 600.00	WK 19	2/19/11		600	0.00	WK 37	6/25/11	1	650.00
2	10/23/10	600.00	20	2/26/11		600	0.00	38	7/2/11		650.00
3	10/30/10	600.00	21	3/5/11		600	0.00	39	7/9/11		650.00
4	11/6/10	600.00	22	3/12/11		600	0.00	40	7/16/11	1	650.00
5	11/13/10	600.00	23	3/19/11		600	0.00	41	7/23/11	1	650.00
7	11/20/10	600.00	25	3/26/11		600	0.00	43	7/30/11	1	650.00
8	11/27/10	600.00	26	4/2/11		650	0.00	43	8/6/11		650.00
9	12/4/10	600.00	27	4/9/11		650	0.00	45	8/13/11	1	650.00
10	12/11/10	600.00	28	4/16/11		650	0.00	46	8/20/11	1	650.00
11	12/18/10	600.00	29	4/23/11		650	0.00	47	8/27/11	1	650.00
12	12/25/10	800.00	30	4/30/11		650	0.00	48	9/3/11		650.00
13	1/1/11	600.00	31	5/7/11		650	0.00	49	9/10/11	1	650.00
14	1/8/11	600.00	32	5/14/11		650	0.00	50	9/17/11	1	650.00
15	1/15/11	600.00	33	5/21/11		650	0.00	51	9/24/11	1	650.00
16	1/22/11	600.00	34	5/28/11		650	0.00	52	10/1/11	1	650.00
	1/29/11	600.00		6/4/11		650	0.00	21. TOT	10/8/11		650.00
17	2/5/11	600.00	35	6/11/11		650	0.00	EAF	NINGS		,800.00
18	2/12/11	600.00	36	6/18/11		650	0.00		OSS AVERAGE EKLY WAGE		50.00

AWW calculation explanation: The employee's wages did not generally vary from week to week, so the "average weekly wages, earnings or salary" for a regular full working week at the time of injury, as defined by §102(4)(A), was \$650.00.

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	RER FILE NUMBE	R:		6. SOCIAL SECU	RITY NU	JMBER	7. \	WCB FILE NUM	MBER:	
2. EMPI	LOYER NAME:	Sales		8. EMPLOYEE LA	AST NAM	ME:	9. FIR	RST NAME: Brian		10. M.I.:
3. EMPI	LOYER MAILING A	DDRESS AND PHONE	NUMBER:	11. ADDRESS-NI	JMBER	AND STREET:				L
4. INSUF	RER NAME:			12. CITY:		13. STATE	14. 2	ZIP: 1	I5. HOME I	PHONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJ		17. DESCRIF	TION O	F INJURY:		
FO IF ` ST				YES NO	BE	DES EMPLOYEE RE ENEFITS THAT MAY ORKERS; COMPEN	STOP W	VHILE ON		YES NO
20. WK		GROSS EARNINGS	WK				WK			
1	11/13/10	500.00	19	3/1	9/11	900.00	37	7/23/1	11	730.00
2	11/20/10	600.00	20	3/2	6/11	775.00	38	7/30/1	11	1500.00
3	11/27/10	400.00	21	4/	2/11	700.00	39	8/6/1	11	1000.00
4	12/4/10	700.00	22	4/	9/11	950.00	40	8/13/1	11	600.00
5	12/11/10	875.00	23	4/1	6/11	900.00	41	8/20/1	11	600.00
6	12/18/10	825.00	24	4/2	3/11	675.00	42	8/27/1	11	725.00
7	12/25/10	775.00	25	4/3	0/11	725.00	43	9/3/1	11	775.00
8	1/1/11	800.00	26	5/	7/11	700.00	44	9/10/1	11	800.00
9	1/8/11	700.00	27	5/1	4/11	800.00	45	9/17/1	11	775.00
10	1/15/11	825.00	28	5/2	1/11	900.00	46	9/24/1	11	950.00
11	1/22/11	750.00	29	5/2	8/11	850.00	47	10/1/1	11	850.00
12	1/29/11	900.00	30	6/	4/11	900.00	48	10/8/1	11	600.00
13	2/5/11	950.00	31	6/1	1/11	1000.00	49	10/15/1	11	710.00
14	2/12/11	875.00	32	6/1	8/11	800.00	50	10/22/1	11	895.00
15	2/19/11	950.00	33		5/11	925.00	51	10/29/1		1000.00
16	2/26/11	700.00	34		2/11	850.00	52	11/5/1		600.00
17	3/5/11	800.00	35		9/11	750.00	21. TO		· ·	705.00
18	2/12/11	800 00	36		6/11	770.00		OSS AVERAGE	, 8N	5 98

AWW calculation explanation: This employee's semi-monthly earnings generally varied, so §102(4)(A) cannot be used. The week ending 11/5/11 includes the date of injury and reduces the AWW, so it should be excluded. The remainder (\$41,105.00) should then be divided by 51 weeks (§102(4)(B)).

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	RER FILE NUMBE	R:		6. SOCIAL SECU	RITY NU	JMBER		7. V	VCB FILE NU	IMBER:	
2. EMPL	OYER NAME:			8. EMPLOYEE LA	AST NAM	1Ε:		9. FIR	ST NAME:		10. M.I.:
	(Office							Adan	n	
3. EMPL	OYER MAILING A	ADDRESS AND PHONE	NUMBER	: 11. ADDRESS-NU	JMBER A	AND STRE	ET:	1			1
4. INSUF	RER NAME:			12. CITY:		1	3. STATE	: 14. Z	IP:	15. HOME F	PHONE:
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF INJ		17.	DESCRIP [*]	TION OF	INJURY:		
				11/9/	/11						
40.00	50 5MDL 0\/55 \M	(ODI)			40.00	SEO EMPL	DVEE DE	25.0/5.5	DINOF		
FO	ES EMPLOYEE W R ANOTHER EMP	LOYER?	N/A C E	YES	BE	DES EMPLO	HAT MAY	STOP W	/HILE ON		YES 🗆
STA		YER SHALL SUBMIT A V EACH ADDITIONAL EMI		NO	VV	ORKERS;	COMPENS	SATION	r.		NO 🗌
20. WK	WEEK ENDING	GROSS EARNINGS	WK					WK			
1	11/20/10	550.00	19	3/26/11		55	50.00	37	7/30/11		600.00
2	11/27/10	550.00	20	4/2/11		55	50.00	38	8/6/11		600.00
3	12/4/10	550.00	21	4/9/11		55	50.00	39	8/13/11		600.00
4	12/11/10	550.00	22	4/16/11		55	50.00	40	8/20/11		600.00
5	12/18/10	550.00	23	4/23/11		55	50.00	41	8/27/11		600.00
6	12/25/10	550.00	24	4/30/11		55	50.00	42	9/3/11		575.00
7	1/1/11	650.00	25	5/7/11		55	50.00	43	9/10/11		600.00
8	1/8/11	550.00	26	5/14/11		60	00.00	44	9/17/11		600.00
9	1/15/11	550.00	27	5/21/11		60	00.00	45	9/24/11		600.00
10	1/22/11	550.00	28	5/28/11		60	00.00	46	10/1/11		600.00
11	1/29/11	550.00	29	6/4/11		60	00.00	47	10/8/11		600.00
12	2/5/11	550.00	30	6/11/11		60	00.00	48	10/15/1	1	600.00
13	2/12/11	550.00	31	6/18/11			00.00	49	10/22/1		600.00
14	2/19/11	550.00	32	6/25/11			00.00	50	10/29/1		650.00
15	2/26/11	550.00	33	7/2/11			00.00	51	11/5/11		650.00
16	3/5/11	550.00	34	7/9/11			00.00	52	11/12/1		130.00
17	3/12/11	550.00	35	7/16/11			00.00	21. TOT			855.00
18			36						OSS AVERAGE		
	3/19/11	550.00		7/23/11		60	00.00	WE	FKI Y WAGE	s 65	0.00

AWW calculation explanation: The employee's wages did not generally vary from week to week, so the "average weekly wages, earnings or salary" for a regular full working week at the time of injury, as defined by §102(4)(A), was \$650.00.

WORKERS' COMPENSATION BOARD STATION 27, AUGUSTA, MAINE 04333-0027

1. INSU	RER FILE NUMBE	R:		6. SOCIAL SECURITY NUMBER		7. WCB FILE NUMBER:					
2. EMPI	LOYER NAME:			8. EMPLOYEE	LAST NA	AME:		9. FIF	RST NAME:		10. M.I.:
		p Agency							Bill		
3. EMPI	LOYER MAILING A	ADDRESS AND PHONE	NUMBER:	11. ADDRESS	-NUMBEF	R AND ST	TREET:				
4. INSUI	RER NAME:			12. CITY: 13. STATE:			: 14. 2	ZIP:	15. HOME	PHONE:	
5. INSU	RER MAILING ADI	DRESS:		16. DATE OF I	NJURY: 10/11		17. DESCRIP	TION O	F INJURY:		
18. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? IF YES, THE EMPLOYER SHALL SUBMIT A WAGE				YES 🗆	E	BENEFIT	MPLOYEE REC	STOP V	VHILE ON		YES 🗆
		EACH ADDITIONAL EMI		NO		WORKER	RS; COMPEN	SATION	· · · · · · · · · · · · · · · · · · ·		NO 🗆
WK	WEEK ENDING	GROSS EARNINGS	WK					WK			
1	11/20/10	600.00	19	3/26/11			0.00	37	7/30/11		0.00
2	11/27/10	600.00	20	4/2/11			0.00	38	8/6/11		500.00
3	12/4/10	500.00	21	4/9/11			0.00	39	8/13/11		900.00
4	12/11/10	600.00		4/16/11			200.00	40	8/20/11		900.00
5	12/18/10	500.00		4/23/11			400.00	41	8/27/11		850.00
6	12/25/10	550.00		4/30/11			600.00	42	9/3/11		825.00
7	1/1/11	625.00		5/7/11			600.00	43	9/10/11		850.00
8	1/8/11	0.00		5/14/11			600.00	44	9/17/11		800.00
9	1/15/11	0.00		5/21/11			600.00	45	9/24/11		750.00
10	1/22/11	0.00		5/28/11			600.00	46	10/1/11		900.00
11	1/29/11	0.00		6/4/11			200.00	47	10/8/11		450.00
12	2/5/11	300.00		6/11/11			0.00	48	10/15/1	1	500.00
13	2/12/11	800.00		6/18/11			0.00	49	10/22/1	1	0.00
14	2/19/11	800.00		6/25/11			0.00	50	10/29/1	1	0.00
15	2/26/11	750.00		7/2/11			0.00	51	11/5/11		200.00
16	3/5/11	750.00	34	7/9/11			0.00	52	11/12/1	1	450.00
17	3/12/11	800.00	35	7/16/11			0.00	21. TO	TAL RNINGS	s 21	,350.00
18	3/19/11	500.00	36	7/23/11			0.00		OSS AVERAGE		4.71

AWW calculation explanation: This employee's weekly earnings generally varied, so §102(4)(A) cannot be used. There were no earnings during the weeks ending 1/8/11, 1/15/11, 1/22/11, 1/29/11, 3/26/11, 4/2/11, 4/9/11, 6/11/11, 6/18/11, 6/25/11, 7/2/11, 7/9/11, 7/16/11, 7/23/11, 7/30/11, 10/22/11 and 10/29/11, so those weeks must be excluded. The week ending 11/12/11 includes the date of injury and reduces the AWW, so it too should be excluded, and the remainder (\$20,900.00) should be divided by 34 weeks (§102(4)(B)). [If, based on the actual circumstances of the employment, §102(4)(B) does not produce a fair and reasonable AWW, comparable employees' wages must be obtained and reviewed along with this employee's previous wages, earnings or salary in order to arrive at a fair and reasonable AWW (§102(4)(D)). §102(4)(C) cannot be used because temp agencies are not seasonal employers.]

APPENDIX C: ADDITIONAL NOC INFORMATION

		Full Denial Reason Codes (DN198)
1	No Comp	ensable Accident
	A	Coming and Going
	В	Horseplay
	C	Willful Intent to Injure Oneself
	D	Does Not Meet Statutory Definition of Accident
	E	Deviation From Employment
	F	Recreational/Social Activity
	G	Traveling Employee
	Н	Subsequent Intervening Accident
2	No Causa	l Relationship
	A	Idiopathic Condition
	В	Pre-existing Condition
	C	Stress Non-Work Related
	D	No Medical Evidence of Injury
	Е	No Injury Per Statutory Definition
	F	Accident Not Major Contributing Cause of Injury
3	No Cover	age
	A	No Employer/Employee Relationship
	В	Independent Contractor
	C	Does Not Meet Statutory Definition of Employee
	D	No Jurisdiction
	Е	No Policy in Effect on the Date of Accident
	F	Statute of Limitation Expired
	G	Statutory Exemptions (Sole Proprietor, Corporate Officer, etc.)
	Н	Elected Other Coverage (24 hour, Collective Bargaining, Opted Out)
4	Substance	
	A	Injury Primarily Occasioned by Intoxication or Use of Any Drug
5	Other (No	ot Elsewhere Classified)
	A	Failure to Report Accident Timely
	C	Misrepresentation

	Partial Denial Reason Codes (DN294)
A	Denying Indemnity in Whole, not Medical
В	Denying Indemnity in Part, not Medical
C	Denying Medical in Whole, Not Indemnity
D	Denying Medical in Part, Not Indemnity
E	Denying Indemnity in Whole, Medical in Part
F	Denying Medical in Whole, Indemnity in Part
G	Denying Both Indemnity & Medical in Part

NOTICE OF CONTROVERSY

WCB FILE # (if known): DN5 THIS IS A DENIAL OF YOUR BENEFITS (Note: the DN Numbers represent a crosswalk to the IAIABC Claims Release 3 EDI data elements.) EMPLOYEE EMPLOYEE LAST NAME FIRST NAME . EMPLOYEE ID **DN43 & DN255 DN44 DN45** DN(42/152/153/154/156) 10. HOME PHONE #: DN270 STREET/P.O. BOX MAILING ADDRESS CITY . STATE NA - DN46 will print all NA boxes with data **NA - DN48** NA - DN50 NA - 51 NA - DN49 11. DATE OF INJURY: 12. SPECIFIC INJURY OR ILLNESS 13. BODY PART(S) AFFECTED: **DN31** NA-DN35 **NA - DN36 EMPLOYER** 4. INSURER/CLAIM ADMIN FILE #: 15. EMPLOYER NAME: 6. EMPLOYER MAILING ADDRESS AND PHONE #: **DN15 NA - DN18** NA - DN168, 165, 170, 167, and 159 17. INSURER/CLAIM ADMIN NAME AND ADDRESS: 18 INSURER/CLAIM ADMIN FEIN DN188, NA – DN10, 12, 13, and 14 **DN187** NOTICE TO EMPLOYEE YOUR EMPLOYER/INSURER IS DENYING YOUR WORKERS' COMPENSATION CLAIM OR PART OF IT. THE REASON FOR THE DENIAL IS CHECKED BELOW.

IF YOU DISAGREE WITH THIS DENIAL, CONTACT A CLAIMS RESOLUTION SPECIALIST AT THE NEAREST REGIONAL OFFICE LISTED BELOW. **FULL DENIAL REASON** PARTIAL DENIAL REASON **DN294 DN198** DATE OF INITIAL INCAPACITY ___/DN56/_ CURRENT DATE OF INCAPACITY /DN144/ FULL DENIAL EFFECTIVE DATE ___/DN199_/_ DATE EMPLOYER NOTIFIED ____/DN281_/_ *NOTE: Reasons identified in boxes 19a or 19b will not preclude a party from raising additional issues at a later date.
21. COMMENTS: DN197 22. If the employer fails to comply with the provisions of Rule 1.1, the employee must be paid total benefits, with credit for earnings and other statutory offsets, from the date the claim is made in accordance with 39-A M.R.S. § 205(2) and in compliance with 39-A M.R.S. § 204. The employer may discontinue benefits under this subsection when both of the following requirements are met: A. The employer files a Notice of Controversy; and B. The employer pays benefits from the date the claim is made. Payment under Rule 1.1 requires filing of a Memorandum of Payment.
 ASSISTANCE IS AVAILABLE AT THE MAINE WORKERS' COMPENSATION BOARD'S REGIONAL OFFICES

 FA
 BANGOR
 CARIBOU
 LEWISTON

 STE 102
 106 HOGAN RD
 ONE VAUGHN PL
 36 MOLLLISON WAY

 ME
 BANGOR, ME
 43 HATCH DR, STE 110
 LEWISTON, ME
 AUGUSTA
24 STONE ST, STE 102
AUGUSTA, ME PORTLAND 62 ELM ST PORTLAND, ME 04330-5220 (207) 287-2308 04401-5638 (207) 941-4550 CARIBOU, ME 04736 (207) 498-6428 04240-7777 (207) 753-7700 04101-3061 (207) 822-0840 1-800-400-6854 1-800-400-6856 1-800-400-6855 1-800-400-6857 1-800-400-6858 23. NAME (TYPE OR PRINT) TELEPHONE #: 25. DATE SENT TO WCB **DN140 DN137** _/DN100_/ -MAIL ADDRESS: 26. DATE RCVD AT THE WCB (WCB use only): **DN138**

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: 1-888-801-9087 or TTY Maine Relay 711. WCB-9 (eff. 1/1/13)

	TICE OF CON	OUR BENEFITS		ta elements)	1. WCB FILE# (if know DN5	vn):
(1vote: the B1v 1vumbers repres	cht a crosswark to the 17	EMPLOYEE	C J LDI dai	a cicincitis.)		
E. EMPLOYEE LAST NAME:	3. FIRST NAME			EMPLOYEE ID		
DN43		DN44	DN45	PF DN270 #	DN(42/152/153/154/15	6)
. STREET/P.O. BOX MAILING ADDRESS: NA — DN46 (will print all NA boxes witblata from F	NA – DI	8. STAT NA -		ZIP: NA – DN50	10. HOME PHONE#: NA - 51	
DN31/	12. SPECIFIC INJURY	OR ILLNESS: NA-DN35		13. BOI	DY PART(S) AFFECTED: NA – DN36	
		EMPLOYER				
. INSURERCLAIM ADMIN FILE#: 1. DN15	5. EMPLOYER NAME: NA – DN18			LING ADDRESS - DN168, 16	AND PHONE 5, 170, 167, and 159	
7. INSURERCLAIM ADMIN NAME AND AD $ m DN188$	DRESS: NA-DN10, 12,	13, and 14		18. INSURER	CLAIM ADMIN FEIN DN187	
19.	ı	NOTICE TO EMPL	O YEE			
					N FOR THE DENIAL IS CHECKED B EGIONAL OFFICE LISTED BELOW.	ELOW.
9a.	AL REASON	19b.			ENIAL REASON	
				FAR HAL D	LINIAL READUN	
DN ² Values (Enter no mo						
1 (A,B,C,D,E,F,G or	H)					
2 (A,B,C,D,E or F)		20a.	INITIAL INICA	PACITY / /		
3 (A,B,C,D,E,F,G,or	H)			CAPACITY/_		
4 (A)		20b.				
		DATE EM	PLOYER NOT	TIFIED//		
5 (A or C) ULL DENIAL EFFECTIVE DATE/DN1	99 /					
NOTE: Reasons identified in boxes 19a or 1		om raising				
dditional issues at a later date.	ion will flot predide a party if					
1.		COMMENTS:				
		DN197 (Enter narration	(0)			
		DIVIS/(Enternatial)	<i>t</i> e)			
- 15 - 110 - 15 - 110 - 1	MELV BURGULANT TO B					
 IF THIS DENIAL NOTICES NOTTI ne date of incapacity in accordance with 38. 						
utomatically ceases upon the filing of a Not						
ASSISTANCE IS AVA	ILABLE AT THE MAINE	WORKERS' COMPE	NSATION E	BOARD'S REG	IONAL OFFICES	
AUGUSTA 24 STONE STSUITE 2 AUGUSTA, ME 04336220	BANGOR 106 HOGAN ROAD BANGOR, ME 044045638	CARIBOU 43 HATCH DRIV CARIBOU, ME 047362347	SEUITE 110 3 L	EWISTON 86 MOLLISON WA EWISTON, ME 042405811	PORTLAND AY 62 ELM ST. PORTLAND, ME 04101-3061	
(207)2872308 (Voice) 1-800-400-6854 (Voice) TTY 1-877-832-5525	(207)941-4550 1-800-400-6856	(207)4986428 1-800-400-6855	((207) 5 3-7700 -800-400-6857	(207)8220840 1800-400-6858	
B. NAME (TYPE OR PRINT):		24. TELEPHONE #:		25. DA	ATE SENT TO WCB:	
DN140		()	137		,DN100 /	
			.51			
MAII ADDDEGO		1		26 DA	TE RCVD AT THE WCB (WCB use of	and A
E-MAIL ADDRESS: DN138				20. 57		onty)

FULL DENIAL OF A LOST TIME C	CLAIM						
	E OF CONT A DENIAL OF YO a crosswalk to the IA	UR BENE	FITS	DI d	ata element	ts.)	WCB FILE # (if known): DN5
		EMPLO	'EE				
EMPLOYEE LAST NAME: DN43 STREET/P.O. BOX MAILING ADDRESS:	3. FIRST NAME: DN 7. CITY:	N 44	4. MI: DN45		DN270	#:	DN(42/152/153/154/156) ME PHONE #:
NA – DN46 (will print all NA boxes with data from FROI)	NA – DN4		NA – DN49		A – DN50		NA - 51
11. DATE OF INJURY: DN31//	12. SPECIFIC INJURY OR IL	LNESS: NA-DN35			13. BO	DY PART	r(s) AFFECTED: NA – DN36
		EMPLOY					
14. INSURER /CLAIM ADMI N FILE #: 15. EMF DN15	PLOYER NAME: NA – DN18		16. EMPLOYER MAI				#: '0, 167, and 159
17. INSURER/ CLAIM ADMIN NAME AND ADDRESS: DN188, NA	– DN10, 12, 13, an	nd 14			18. INSURER/	CLAIM	ADMIN FEIN: DN187
19. YOUR EMPLOYER/INSURER IS DENYING YOU IF YOU DISAGREE WITH THIS DENIAL	UR WORKERS' COMPENSAT	TON CLAIM OF					
19a. FULL DENIAL REA	ASON	19	ðb.		PARTIAL DE	ENIAL F	REASON
DN198 Values (Enter no more t	han five):						
1 (A,B,C,D,E,F,G or H)		20					
2 (A,B,C,D,E or F)			ATE OF INITIAL INC	CAPAC	лтү/ DN	N56/	
3 (A,B,C,D,E,F,G,or H)		С	URRENT DATE OF				
4 (A)		Ī	ATE EMPLOYER NOT	TFIED	/ Di	N281∠	<u></u>
5 (A or C) FULL DENIAL EFFECTIVE DATE /DN199_/_							
*NOTE: Reasons identified in boxes 19a or 19b will not pre additional issues at a later date.	eclude a party from raising						
21.		COMMENT	<u>S:</u>				
	<u>D</u>	N197 (Enter	narrative)				
22. IF THIS DENIAL NOTICE IS NOT TIMELY the date of incapacity in accordance with 39 -A M.R.S. automatically ceases upon the filing of a Notice of Controv	 A. § 205(2) and in compliance 	e with 39 -A I	M.R.S.A. § 204. The re	equirem	ent for payment	t of benef	ngs and other statutory offsets, from its under this subsection if a Memorandum of Payment.
ASSISTANCE IS AVAILA						REGIO	
24 STONE ST. SUITE 2 106 AUGUSTA, ME BA. 04330 - 5220 044 (207)287 - 2308 (Voice) (20' 1-800-400-6864 (Voice) 1-8 TTY 1 -877-832 -5525	NGOR HOGAN ROAD NGOR, ME D1 -5638 7)941 -4550 800 -400 -6856	CARIBOU 43 HATCH DRI CARIBOU, M 04736 -234 (207)498 -6 1 -800-400-	VE SUITE 110 IE 17 1428 6855	04240 (207)7	OLLISON WAY TON, ME -5811 53-7700 -400-6857		PORTLAND 62 ELM ST. PORTLAND, ME 04101 -3061 (207)822 -0840 1 -800 -400 -6858
23. NAME (TYPE OR PRINT): DN140	2	4. TELEPHON	E#: DN137		25. D/	ATE SEN	T TO WCB: _/ DN100_/
E-MAIL ADDRESS: DN138					26. DA	TE RCVI	D AT THE WCB (WCB use only) :

WCB -9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services, o r activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephone: 1 -888-801-9087 or TTY (877) 832 -5525.

DISTRIBUTION: COPY (1) EMPLOYEE, (2) EMPLOY ER

PARTIAL DENIAL OF INITIAL	INCAPACITY					
THI	TICE OF CON'S IS A DENIAL OF YO	OUR BENEFITS	;	T 1		WCB FILE# (if known): DN5
(Note: the DN Numbers represe	ent a crosswalk to the IA	IABC Claims Re EMPLOYEE		I data elen	nents.)	
2. EMPLOYEE LAST NAME: DN43	3. FIRST NAME:	N44	4. MI: DN45	5. EMPLOY		DN(42/152/153/154/156)
6. STREET/P.O. BOX MAILING ADDRESS: NA — DN46 (will print all NA boxes wittlata from FI	NA – DN		TATE: A – DN49	9. ZIP: NA – D	10.	HOME PHONE#: NA - 51
11. DATE OF INJURY: DN31 //	12. SPECIFIC INJURY	OR ILLNESS: NA-DN35			3. BODY F	PART(S) AFFECTED: NA – DN36
		EMPLOYER				
14. INSURERCLAIMADMINFILE#: 15 DN15	5. EMPLOYER NAME: NA – DN18		EMPLOYER			D PHONE 170, 167, and 159
17. INSURERCLAIM ADMIN NAME AND $\overline{ m ADN}188$	DRESS: NA-DN10, 12, 1	3, and 14		18. II	NSURER¢LA	NIMADMIN FEIN DN187
19. YOUR EMPLOYER/INSURER IS DE IF YOU DISAGREE WITH TH	ENYING YOUR WORKERS' C	OTICE TO EMICOMPENSATION CLAIMS RESOLUTION	AIM OR PAR	T OF IT. TH	E REASON I	FOR THE DENIAL IS CHECKED BELOW GIONAL OFFICE LISTED BELOW.
19a.	AL REASON	19b.				IAL REASON
				Val	DN29 ues = A,B	
		20a.				
			OF INITIAL II			
FULL DENIAL EFFECTIVE DATE _//_					Bulan	
*NOTE: Reasons identified in boxes 19a or 1 additional issues at a later date.	19b will not preclude a party fro	om raising DATE	EMPLOYER I	NOTIFIED	<u>D</u> M28	1 <u>/</u>
21.		COMMENTS:				
		DN197(Enter narı	,			
22. IF THIS DENIAL NOTICES NOTTING the date of incapacity in accordance with 39 automatically ceases upon the filing of a Notice.	M.R.S.A.§ 205(2) and in comp	liance with 38 M.R.S	.A. § 204. TI	ne requireme	nt for payme	ent of benefits under this subsection
ASSISTANCE IS AVA	ILABLE AT THE MAINE	WORKERS' CO	IPENSATIO	ON BOAR	'S REGIO	NAL OFFICES
AUGUSTA 24 STONE STSUITE 2 AUGUSTA, ME 043356220 (20772872308 (Voice) 1-800-400-6854 (Vbice) TTY 1-877-6822-5525	BANGOR 106 HOGAN ROAD BANGOR. ME 0440*5638 (207)9414550 1-800-400-6856	CARIBOU 43 HATCH I CARIBOU, ME 0473&2347 (207)49&428 1800-400-6855	PRISIBITE 110	LEWISTO 36 MOLLI LEWISTO 0424681 (207)\$3-7 1800-400-6	SON WAY N, ME 1 700	PORTLAND 62 ELM ST. PORTLAND, ME 04101-3061 (207)8220840 1800-400-6858
23. NAME (TYPE OR PRINT): DN140		24. TELEPHONE #	DN137		25. DATE	SENT TO WCB:DN100_/
E-MAIL ADDRESS: DN138					26. DATE I	RCVD AT THE WCB (WCB use only)

WCB-9 (1/12/06) The State of Maine does not discriminate on the basis of disability in admission to, actaesor operation of its programs, services, or activities. This form is available in alternative format. For further assistance, contact the Maine Workers' Compensation Board, ADA Coordinator, telephase301-9087 or TTY (877) 8325525. DISTRIBUTIONCOPY (1) EMPLOYEE,2) EMPLOYER

(Note: the DN Numbers repres	S IS A DENIAL	AIM CONTROV L OF YOUR BENE to the IAIABC Clair EMPLOY	EFITS ms Release 3 EI				E# (if known): DN5
. EMPLOYEE LAST NAME: DN43	3. FIRS	ST NAME: DN44	4. MI: DN45	5. EMPLOYEE I)		
		DN44		TYPE DN270	#:	N(42/152/153	/154/156)
. STREET/P.O. BOX MAILING ADDRESS NA – DN46		IA – DN48	8. STATE: NA – DN49	 ZIP: NA – DN5 		ME`PHONE: NA - 51	
(will print all NA boxes with data from FR	ROI)						
DN31/	12. SPECIFIC	C INJURY OR ILLNESS: NA-DN35		13.	BODY PAR	T(S) AFFECTED: NA – DN36	
		EMPLO	/ER				
. INSURERCLAM ADMINFILE#: 15 DN15	5. EMPLOYER NAM NA –	ME: - DN18	16. EMPLOYER			HONE), 167, and 15	9
7. INSURERCLAIMADMINNAMEAND AD	DRESS:		-1	18. INSU	RERCLAIM	ADMINFEIN	
DN188	NA-DN10,	, 12, 13, and 1	14			DN187	
19.		NOTICE TO	EMPLOYEE				
YOUR EMPLOYER/INSURER IS D IF YOU DISAGREE WITH TI	ENYING YOUR WO	ORKERS' COMPENSAT	ION CLAIM OR PA	RT OF IT. THE	REASON FO	OR THE DENIAL IS	CHECKED BELOW.
9a.			9b.				ILD BELOW.
FULL DENIAL	L REASON			PARTIAL	DENIAL R	EASUN	
					DN294		
				Valu	ies = C d	or D	
		2	0a.				
		г	NATE OF INITIAL IN	VICADACITY	11		
			DATE OF INITIAL INCURRENT DATE OF				
AND DENIAL EFFECTIVE DATE.		C					
		2	CURRENTDATEOF	INCAPACITY_			
NOTE: Reasons identified in boxes 19a or		2	CURRENTDATEOF 0b.	INCAPACITY_			
IOTE: Reasons identified in boxes 19a or iditional issues at a later date.		e a party from raising	CURRENTDATEOF 0b. NATE EMPLOYER N	INCAPACITY_			
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NOTE: Reasons identified in boxes 19a or dditional issues at a later date.		e a party from raising COMMENT	CURRENTDATEOF Ob. PATE EMPLOYER I	INCAPACITY_			
NOTE: Reasons identified in boxes 19a or ditional issues at a later date. 1. 2. IF THIS DENIAL NOTICE IS NOT TIME	19b will not preclude	e a party from raising COMMENT DN197 (Enter	CURRENTDATEOF Ob. PATE EMPLOYER I S: narrative)	NOTIFIED		earnings and other	statutory offsets, from
IOTE: Reasons identified in boxes 19a or iditional issues at a later date. 2. IF THIS DENIAL NOTICE IS NOT TIME ada to fincapacity in accordance with 390 and 190 ada to fincapacity in accordance with 390 and 190 ada to fincapacity in accordance with 390 and 190 ada to fincapacity in accordance with 390 and 190 ada to fincapacity in accordance with 390 and 190 ada to fincapacity in accordance with 390 and 190 ada to fincapacity in accordance with 390 ada to fincapacity with	19b will not preclude WELY PURSUANT T M.R.S.A.§ 205(2) an	e a party from raising COMMENT DN197 (Enter	CURRENTDATEOF Ob. PATE EMPLOYER I S: narrative) Doloyee must be pair M.R.S.A. § 204. Ti	NOTIFIED otal benefits, with	o credit for e	of benefits under tr	is subsection
NOTE: Reasons identified in boxes 19a or diditional issues at a later date. 1. 2. IF THIS DENIAL NOTICE IS NOT TIME of the property of the p	19b will not preclude WELY PURSUANT T M.R.S.A.§ 205(2) an	e a party from raising COMMENT DN197 (Enter	CURRENTDATEOF Ob. PATE EMPLOYER I S: narrative) Doloyee must be pair M.R.S.A. § 204. Ti	NOTIFIED otal benefits, with	o credit for e	of benefits under tr	is subsection
NOTE: Reasons identified in boxes 19a or dditional issues at a later date. 1. 2. IF THIS DENIAL NOTICE IS NOT TIN the date of incapacity in accordance with 39 utomatically ceases upon the filing of a No	19b will not preclude MELY PURSUANT T M.R.S.A.§ 205(2) an tice of Controversy a	e a party from raising COMMENT DN197 (Enter TO RULE 1.1 , the emmed in compliance with 39 and the payment of anyeing and the payment of anyeing 20 and the payment of anyeing 20 and the payment of anyeing 20 and 20 anyeing 20 anyein	CURRENTDATEOF Ob. PATE EMPLOYER I S: narrative) Doloyee must be paint M.R.S.A. § 204. Til addozenefits.Payment	otal benefits, with the requirement funder Rule 1.1 re	n credit for a	of benefits under the of a Memorandum	is subsection
ULL DENIAL EFFECTIVE DATE/_ NOTE: Reasons identified in boxes 19a or dditional issues at a later date. 1. 2. IF THIS DENIAL NOTICE IS NOT TIPE to date of incapacity in accordance with 39 utomatically ceases upon the filing of a No	MELY PURSUANT T M.R.S.A.§ 205(2) an tice of Controversy a	e a party from raising COMMENT DN197 (Enter TO RULE 1.1 , the emmed in compliance with 39 and the payment of anye E MAINE WORKERS	CURRENTDATEOF Ob. ATE EMPLOYER I S: narrative) Doloyee must be pair M.R.S.A. § 204. Ti addozenefits Payment	otal benefits, withe requirement funderRule 1.1 re	n credit for a	of benefits under tr of a Memorandum	is subsection
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IOTE: Reasons identified in boxes 19a or iditional issues at a later date. 2. IF THIS DENIAL NOTICE IS NOT TIP e date of incapacity in accordance with 39 itomatically ceases upon the filing of a No ASSISTANCE IS AVA AUGUSTA 24 STONE SBUITE 2 AUGUSTA, ME	MELY PURSUANT T M.R.S.A.§ 205(2) an tice of Controversy a MLABLE AT THE BANGOR 106 HOGAN RO BANGOR, ME	e a party from raising COMMENT COMMENT DN197 (Enter TO RULE 1.1 , the emm of in compliance with 39 and the payment of anye E MAINE WORKERS CARIBO A3 HA CARIBO CARIBO CARIBO CARIBO	CURRENTDATEOF Ob. PATE EMPLOYER I S: narrative) Doloyee must be pair M.R.S.A. § 204. Ti addoenefits Payment COMPENSATI U TICH DREMETE 110 U U, ME	otal benefits, withe requirement frunder Rule 1.1 re ION BOARD'S LEWISTON 36 MOLLLISON LEWISTON 10 MOLLISON LEWISTON LE	n credit for or payment quires filing	AL OFFICES PORTLAND 62 ELM ST. PORTLAND,	is subsection of Payment.
OTE: Reasons identified in boxes 19a or iditional issues at a later date. I. IF THIS DENIAL NOTICE IS NOT TIME at date of incapacity in accordance with 39 itomatically ceases upon the filing of a Notational ASSISTANCE IS AVAINGUSTA A 24 STONE STBUITE 2 AUGUSTA, ME 04336220 (207)282308 (Voice)	MELY PURSUANT T M.R.S.A.§ 205(2) an dice of Controversy a MILABLE AT THE BANGOR 106 HOGAN RO BANGOR, ME 04405638 (207)9414550	e a party from raising COMMENT DN197 (Enter TO RULE 1.1 , the emm of in compliance with 39 and the payment of anye E MAINE WORKERS OAD 43 HA CARIBO 047363 (207)49	CURRENTDATEOF Ob. PATE EMPLOYER I S: narrative) Doloyee must be paint M.R.S.A. § 204. Ti addozenefits Payment O' COMPENSATI UITCH DRSUBTE 110 UU, ME 47 8428	otal benefits, withe requirement funder Rule 1.1 re ION BOARD'S LEWISTON 042468811 (20793-7700	n credit for or payment quires filing	AL OFFICES PORTLAND 62 ELM ST. PORTLAND, 04101-3061 (207)8220840	us subsection of Payment.
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ACTE: Reasons identified in boxes 19a or diditional issues at a later date. 1. 2. IF THIS DENIAL NOTICE IS NOT TIME of the control of the c	MELY PURSUANT T M.R.S.A.§ 205(2) an dice of Controversy a MILABLE AT THE BANGOR 106 HOGAN RO BANGOR, ME 04405638 (207)9414550	E MAINE WORKERS CARIBO AD AD AD AD ABA CARIBC 047343 (207)494 4800-400	CURRENTDATEOF Ob. ATE EMPLOYER I S: narrative) Doloyee must be pair M.R.S.A. § 204. Ti addozenefits Payment O'COMPENSATI U.TCH DRSUBTE 110 U, ME 47 3428 6855	otal benefits, withe requirement funderRule 1.1 re ION BOARD'S LEWISTON D 36 MOLLISON LEWISTON M 042468811 (207)33-7700 4800-400-6857	n credit for or payment quires filing REGION WAY	AL OFFICES PORTLAND 62 ELM ST. PORTLAND 04101-3061 (207)8220840 1800-400-6858	us subsection of Payment.
ASSISTANCE IS AVA AUGUSTA 24 STONE SBUITE 2 AUGUSTA, ME 04336220 (207)282308 (Voice) 1-800400-6854 (Voice) TTY 1-877-832-5525 3.NAME (TYPE OR PRINT): DN140	MELY PURSUANT T M.R.S.A.§ 205(2) an dice of Controversy a MILABLE AT THE BANGOR 106 HOGAN RO BANGOR, ME 04405638 (207)9414550	e a party from raising COMMENT DN197 (Enter TO RULE 1.1 , the emm and in compliance with 39 and the payment of aruse E MAINE WORKERS CARIBO 43 HA CARIBC 047363 (207)494 4800-400	CURRENTDATEOF Ob. ATE EMPLOYER I S: narrative) Dioyee must be pair M.R.S.A. § 204. Ti eldosenefits Payment O'COMPENSATI U, ME 1747 18428 6855 DNE #:	otal benefits, withe requirement frunderRule 1.1 re ION BOARD'S LEWISTON 0 36 MOLLLISON 0.12468811 (20793-7700 1800-400-6857	n credit for or payment quires filing REGION WAY LE DATE SE	AL OFFICES PORTLAND 62 ELM ST. PORTLAND, 04101-3061 (207)8220640 1800-400-6858 NT TO WCB: DN100_/	ME
ASSISTANCE IS AVA AUGUSTA 24 STONE S'BUITE 2 AUGUSTA, ME 04336220 (2071282308 (Voice) 1-800400-6854 (Voice) TTY 1-877-832-5525 3. NAME (TYPE OR PRINT):	MELY PURSUANT T M.R.S.A.§ 205(2) an dice of Controversy a MILABLE AT THE BANGOR 106 HOGAN RO BANGOR, ME 04405638 (207)9414550	e a party from raising COMMENT DN197 (Enter TO RULE 1.1 , the emm and in compliance with 39 and the payment of aruse E MAINE WORKERS CARIBO 43 HA CARIBC 047363 (207)494 4800-400	CURRENTDATEOF Ob. ATE EMPLOYER I S: narrative) Dioyee must be pair M.R.S.A. § 204. Ti eldosenefits Payment O'COMPENSATI U, ME 1747 18428 6855 DNE #:	otal benefits, withe requirement frunderRule 1.1 re ION BOARD'S LEWISTON 0 36 MOLLLISON 0.12468811 (20793-7700 1800-400-6857	n credit for or payment quires filing REGION WAY LE DATE SE	AL OFFICES PORTLAND 62 ELM ST. PORTLAND 04101-3061 (207)8220840 1800-400-6858	ME

	ICE OF CON'S IS A DENIAL OF YO	OUR BENEFITS		ata eleme	ents)			E# (if known): DN5
(11ote: the B1111tumbers represen	it it crosswant to the 171	EMPLOYEE	ise 3 EDI u	utu cicinc	A1(3.)			
2. EMPLOYEE LAST NAME:	FIRST NAME:			5. EMPLOY	/EE ID:			
DN43	L	DN44	DN45	TYPF: DN	2 7 0 #-	D	N(42/152/153	/154/156)
s. STREET/P.O. BOX MAILING ADDRESS: NA - DN46 (will print all NA boxes withdata from FR	7. CITY: NA – DN	8. ST NA NA	ATE: . – DN49	9. ZIP: NA – [1	0. HON	IE PHONE#: NA - 51	,
11. DATE OF INJURY: DN31/	12. SPECIFIC INJURY	OR ILLNESS: NA-DN35			13. BOD	Y PART	(S) AFFECTED: NA – DN36	
		EMPLOYER						
14. INSURERCLAIM ADMINFILE#: DN15	. EMPLOYER NAME: NA – DN18		MPLOYER M N				N E : 167, and 159	
7. INSURERCLAIM ADMIN NAME AND ADD DN188,	NA-DN10, 12, 1	13, and 14		18.	INSURERA	CLAIM A	DMIN FEIN: DN187	
19. YOUR EMPLOYER/INSURER IS DEN	NYING YOUR WORKERS' C	NOTICE TO E MP	M OR PART O	OF IT. THE	REASON	FOR TH	IE DENIAL IS CHE	CKED BELOW.
IF YOU DISAGREE WITH THIS 19a. FULL DENIA		AIMS RESOLUTION SE	-ECIALIST A				REASON	DELUW.
				Val	DN lues = A	294 ,B,E ,F	= or G	
		CURRE	F INITIAL IN NTDATE OF			56/ \144/_		
FULL DENIAL EFFECTIVE DATE _//			MPLOYER N	OTIFIED	DN2	281 <i>_j</i> _		
21.		COMMENTS:						
22. IF THIS DENIAL NOTICES NOTTIM he date of incapacity in accordance with 39. M automatically ceases upon the filing of a Notice	M.R.S.A. § 205(2) and in comp	oliance with 39A M.R.S.	must be pail to A. § 204. The	e requireme	ent for payr	nent of b	penefits under this	subsection
ASSISTANCE IS AVAIL	LABLE AT THE MAINE	WORKERS' COMP	ENSATION	BOARD'	S REGIO	NAL C	FFICES	
AUGUSTA 24 STONE STSUITE 2 AUGUSTA, ME	BANGOR 106 HOGAN ROAD BANGOR, ME 044015638 (207)941-4550	CARIBOU 43 HATCH DR CARIBOU, ME 047%-2347 (207)4986428 1800-400-6855	IV S UITE 110	LEWISTO 36 MOLL LEWISTO 0424058 (207)53- 1-800-400	ISON WAY ON, ME 11 7700	(PORTLAND 62 ELM ST. PORTLAND. N 04101-3061 (207)8220840 1-800-400-6858	
043365220 (207)2872308 (Voice) 1-800-400-6854 (Voice) TTY 1-877-832-5525	1-800-400-6856							
(207)2872308 (Voice) 1-800-400-6854 (Voice) TTY 1-877-832-5525 23. NAME (TYPE OR PRINT):	1-800-400-6856	24. TELEPHONE #:			25. DA	TE SEN	T TO WCB:	
(207)2872308 (Voice) 1-800-400-6854 (Voice) TTY 1-877-832-5525	1-800-400-6856	()	N137		25. DA	TE SEN	T TO WCB:	

APPENDIX D: SEVEN-DAY WAITING PERIOD

The following methods of calculating the seven-day waiting period are acceptable for purposes of Board audits:

In the case of ongoing total incapacity, the seven-day waiting period is met when the employee is incapacitated for seven calendar days. In the case of partial incapacity, the seven-day waiting period is met when (1) [AWW Method] an employee loses wages because of the injury which cumulatively equal or exceed the employee's pre-injury AWW, or (2) [Comp Rate Method] loses wages because of the injury that would otherwise require the insurer to pay one week of benefits.

In the case of ongoing total incapacity, the seven-day waiting period becomes compensable when the employee is incapacitated for more than 14 calendar days. In the case of partial incapacity, the seven-day waiting period becomes compensable when (1) [AWW Method] an employee loses wages because of the injury which cumulatively exceed two times the employee's pre-injury AWW, or (2) [Comp Rate Method] loses wages because of the injury that would otherwise require the insurer to pay more than two weeks of benefits.

Example: Assume January 1999 date of injury, married/joint with one dependent filing status.

Weekly Compensation Rate

 Pre-Injury AWW
 \$650.00
 \$417.00

 Post-Injury Wage
 \$450.00
 \$302.52

\$114.48 Partial Weekly Benefit Rate

AWW Method

	Pre-injury	Post-injury	Lost Earnings	Cumulative	Weekly
	AWW	AWW		Lost Earnings	Benefits Due
Week 1	\$650.00	\$450.00	\$200.00	\$200.00	
Week 2	\$650.00	\$450.00	\$200.00	\$400.00	
Week 3	\$650.00	\$450.00	\$200.00	\$600.00	
Week 4	\$650.00	\$450.00	\$200.00	\$800.00	\$114.48
Week 5	\$650.00	\$450.00	\$200.00	\$1,000.00	\$114.48
Week 6	\$650.00	\$450.00	\$200.00	\$1,200.00	\$114.48
Week 7	\$650.00	\$450.00	\$200.00	\$1,400.00	\$457.92
Week 8	\$650.00	\$450.00	\$200.00	\$1,600.00	\$114.48
Week 9	\$650.00	\$450.00	\$200.00	\$1,800.00	\$114.48
Week 10	\$650.00	\$450.00	\$200.00	\$2,000.00	\$114.48
Total					\$1,144.80

Comp Rate Method

	Partial Weekly Benefit Rate	Cumulative Partial Weekly Benefit	Weekly
		Rate	Benefits Due
Week 1	\$114.48		
Week 2	\$114.48	\$228.96	
Week 3	\$114.48	\$343.44	
Week 4	\$114.48	\$457.92	\$40.92
Week 5	\$114.48	\$572.40	\$114.48
Week 6	\$114.48	\$686.88	\$114.48
Week 7	\$114.48	\$801.36	\$114.48
Week 8	\$114.48	\$915.84	\$531.48
Week 9	\$114.48	\$1,030.32	\$114.48
Week 10	\$114.48	\$1,144.80	\$114.48
Total		\$1,144.80	\$1,144.80

APPENDIX E: FROI CROSSWALK

EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

(Note: the DN Numbers represent a crosswalk to the IAI ABC Claims Release 3 EDI data elements.)

1. WCB FILE NUMBER (if known): ENS
Tis CSHA 300 CASE NUMBER: (if applicable):

REASON FOR REPORT (check all fliatapply)							
28. LOST TIME - ONE OR MOREDAYS DN74 26. WAS EMPLOYEE PAD FOR NDAY OR MORE ON DAY OF NURYY PES NO NA							
>. □ LOSTERRN NGS BU TNOLOST TIME N	4. ☐ MEDICAL HEALTH CARE DN74 5. ☐ FAITAL ITY DAITE OF DEATH:(/ DN57						
Also see DN146 MM DD YYYY *a. □ occupational disease DN290							
YYYY MM DD YYYY MM DD							
1a. ☐ CORRECTPRIOR REPORT DN2 1b. DATE OF CORRECTON: C/ DN3 1c. DATE CORRECT							
Note talso see correction process	AX DINAN AR	1.84	DD YYYY			MAN DD YYYY	
:.STATE EMPLOYER UNEMPLOYMENT				n and the DMIC	1# .EMPLOYER NAM	- DNHO	
NSUR ANCE ACCOUNT NUMBER (URN): DN323	9.FEDERALEMPLO	EK DENTIFI	IN TION NOMES	:K (PE N): DINIO	IV.EMPLO YER NAM	E: DINIO	
11.STREET/PID BOXMA LING ADDRESS: DN168-169	е.city:DNI66	e.city:DN166			14.2 P : DN167	15. TELEPHONE NUMBER: DNI 59	
* .PR MAR YBUSINESS PERFORMED BY EMPLOYER WHE RE INJURYOCCUR RED :	11. EMPLOYER LOCA Mailing ad dress:		17.00 Hour for Exposure occorrences to ten of remises.				
DN25	DN19-23	DNA9					
DI-ES		EMPLOYER PHYSICAL COUNTRY FNO, THEN 9 IVE NAME AND PHYSICAL ADDRESSOF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED : DN/120; 119, 122, 121, 123, 33, 118					
	CODE = DN164				E COUNTRY CODE = D		
	П.						
(oheoklone) INSURER * .NSURANCE / TPA COMPANYNAME:		IIRD PART	Y A DWINIST	RATOR (TPA)		ELF-ADMINISTERED EMPLOYER	
EN7/188	29 .POLICYNUMBER : DN28				: 1. INSURER FILE NUMB	ER: LINTS	
22 .STREETIP O . BOX MAILING ADDRESS: EN10-11	ellery: DNI2	ecomy: DNI 2			25.Z P: DN14	24. TELEPHONE NUMBER: ()NA	
21.LEST NAME: DN4.38. DN255 22.FRST NAME: DN44			29.Mt > TE		ELEP HONE \$ 1.300 RL SECUR ITY NUMBER: \$2.GENDER:		
I I I I I I I I I I I I I I I I I I I		DN45		NUMBER:	D N4 2 51	□ MALE □ FEMALE	
33 .STREETIP O . BOX MAILING ADD RESS: 34.0 (TY: DN48)			_	ж. зтат е: DN49	34.2 P : DN50	21 JOATE OF BIRTH: DN52	
DN4647							
						HAM DD YYYY	
⇒ .occupationage time: DN60 > .date of hise: DN61		31 4.1	4. WEEKLY WAGE AT TIME OF INJURY:		41.0 DESEMPLOYEE WORK FOR ANOTHER EMPLOYER?		
/		≰ D	\$ DN62		☐ YES ☐ NO FIYES, GIVE NUME AND ADD RESS:		
	MM DD YYYY		NA NA				
42 .DATE OF INJURYOR LUNESS:	B.DATE OF INCAPACITY:		RME EMPLOYE! .12 € a.m.):	E BEGAN WORK	45 .D & TE EMPLOYER NO	TFIED INSURER/TPA OF INJURY:	
(DN31	/(DN56	NA.	. i z e dang.		//_ DN	1	
	MM DD YYYY		u		MAN DD YYYY		
DATE EMPLOYER NOTIFED:	IN THE EMPLOYER NO THE ED :	# TIME OF NUR Y(e.g. 1:0 p.m.): 41.HAS EMPLOYEE RETURNED TO WORK? ☐ YES ☐ NO DM1 EMPLOYER NOTIFIED: DN32					
		F YES, GWE DATE:/ DNBS					
# .SPECIFIC NJUR YOR LLNESS	ECFICINUM YOR LLINESS U. BODY PART(s) AFFECTED (e.g. lower right for earns): [5 - ALL ECUPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS						
(e.g. second degree burn or toxic hepatitis): [N35]	DNB6				USING WHEN THE EVEN TOO DN37	CUR RED (e.g. acetylene torch, metal plate):	
51.SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT 51.HOW INJURYOR ILLNESSOCKURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS O OCCURRED (e.g. cuting metal plate for freeing): SUBSTRICES THAT IN RECTLY NUMBER OR MADE THE EMPLOYEE ILL. (e.g. water stepped back to inspect work and							
Slipped on some scrap metal. A sworter Mil, worker brushed against hot metal (c. DNSS							
53. HOSPITALIZED OVERNIGHT AS INPATIENT?	 WAS THE EMPLOYEE TREATE N AN EMERGENCY ROOM? 	55. HEALTH CA	RE PROVICER NA	ME SK. MALN	G AD DR E33:	\$1. TELEPHONE NUMBER:	
□ YES □ NO NA	□ YES □ NO NA	NA		NA.		()NA	
SO .PREPARER NAME AND TITLE (TYPE OR PRIN	59.1	. TE LEPHONE NUMBER :			DATE SENT TO WCB: DN100		
NA	-) NA			The second of th	
			-				
The State of Maine provides equal op	nortunitacio emploame	of and no	orans A	viliant aids and e	<u>l</u> enices are available e	MM DD YYYY o individuals with disabilities upon	
request. For assistance with this form							
Relay 711. MICR-1 6# 1/1/13)							